DOCUMENT RESUME

ED 385 364 PS 023 432

AUTHOR Fenichel, Emily, Ed.
TITLE [Clinical Responses To Infants and Families.]
INSTITUTION National Center for Clinical Infant Programs, Arlington, VA.
REPORT NO ISSN-0736-8086
PUB DATE Mar 95
NOTE 41p.
AVAILABLE FROM Zero to Three, National Center for Clinical Infant Programs, P.O. Box 25494, Richmond, VA 23260-5494.
PUB TYPE Reports - Research/Technical (143) -- Collected Works - Serials (022)
JOURNAL CIT Zero to Three; v15 n4 Feb-Mar 1995

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Adolescents; *At Risk Persons; Black Mothers; Blacks; Case Studies; Caseworkers; Child Behavior; Child Caregivers; Child Development; Community Services; Counseling Techniques; *Family (Sociological Unit); Home Programs; Home Visits; *Infants; *Intervention; Mental Health Workers; Parent Child Relationship; Parents; *Social Services; Social Work; *Social Workers; Unwed Mothers
IDENTIFIERS African Americans; *Family Support

ABSTRACT

This journal issue focuses on family service clinical responses to infants and families. In "The Therapeutic Relationship as Human Connectedness," Jeree H. Pawl stresses the importance of caregivers creating in children the sense and experience of human connectedness that arises from the feeling of existing in the mind of someone else--that is, being noticed, spoken to, protected, appreciated. In "'She Does Love Me, Doesn't She?'" Deborah J. Weatherston describes a program in which infant mental health specialists provide in-home services to infants and families that are psychologically and socially at-risk for neglect or abuse. Important support strategies are also identified. In "Using the Principles of Infant-Parent Psychotherapy To Change the Context for Children at Risk," Brenda P. Jones demonstrates that what clinicians do will matter to families at high environmental and individual risk, and that a clinician can deal with psychological issues and adapt traditional methods for families at risk; three primary therapeutic principles are identified. In "A Home-Based, Family Systems Approach to the Treatment of African-American Teenage Parents and Their Families," JoAnn Tatum and others describe a home-based family therapy program for adolescent parents and their extended families. The article suggests cultural issues relating to families and systemic intergenerational family issues relating to teen pregnancy must be discussed in relation to the African-American experience. In "The Interweaving of Neuropsychological Dysfunction and Psychological Conflict," Lois M. Black argues that neuropsychological conditions (brain-based dysfunctions) play a role in children's behavior and development, and that neuropsychological dysfunction and psychological conflict interact. Annotated lists of publications and videotapes included. Some articles contain references. (TM)

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The Therapeutic Relationship as Human Connectedness:

Being held in another's mind

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

This essay is excerpted from the opening plenary session of ZERO TO THREE's Ninth National Training Institute, held in Dallas, Texas, December 1-4, 1994.

A challenging, exceedingly demanding, and lovable woman with whom I worked as an infant/parent therapist over five years told me once that she would be happy to talk to others about what in our work had seemed important to her, what things had mattered. One morning, we videotaped an hour of conversation. Here are some of the things this young woman said:

Continued on page 3

Editor's Note

This issue of Zero to Three is about clinical responses to infants and families. Because the word "clinical" can be understood to mean either "direct observation and treatment" or "very objective, devoid of emotion," it is not surprising that the word evokes such strong — and disparate — reactions among people within and beyond our field. When Sally Provence and I once tried to identify elements that characterize a "clinical response," we came up with four, which readers of the thoughtful essays in this issue may wish to keep in mind:

1. A clinical response rests on a conceptual framework for understanding developmental issues and problems in children and parents in the earliest years of life. Whatever the individual clinician's particular background and theoretical perspective may be, the connection between key concepts and clinical practice should be evident, or at least traceable, in every encounter between professional and family, providing a rationale for the practitioner's words and actions.

2. A clinical response must address the particular, unique needs of an individual child or family. Despite pressures to "standardize" assessment protocols, program design and requirements for participation, and even topics of discussion in home visits, a clinically responsive program strives to serve individual families appropriately. This involves: accommodation in service delivery, whenever possible, to the particular circumstances at hand; cultural sensitivity; attention to families' expressed needs; and the flexibility to address issues that may only emerge over time.

3. A clinical response involves awareness of, and reflection upon, the helping relationship itself. What mental health practitioners have called "the professional use of self" is key to establishing and maintaining parent-professional relationships that can support the infant's development.

4. A clinical response takes place within a system of care that, ideally, supports the practitioner as well as the child and family. Training, programs' administrative policies, the organization of services at the community level, and public policies affecting infants, toddlers, and their families are all part of a context that supports — or fails to support — the development of young children, as well as the professional growth of people — like the readers of Zero to Three — who undertake and persist in the difficult work of a reflective practice with infants and parents.

Emily Fenichel, Editor

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ISSN 0736-8086

© 1995 ZERO TO THREE/National Center for Clinical Infant Programs

2000 14th street North, Suite 380, Arlington, VA 22201-2500
Tel. (703) 528-4300

Publications orders: 1-800-899-4301

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The Therapeutic Relationship as Human Connectedness

(continued from page 1)

I remember a lot of times when we came here, there was this doll that my daughter loved.
She named her Baby Lyn.
And every time we'd come, that doll was there.
I remember one particular day when we came, the doll wasn't there, and she was so broken-hearted that ***you*** *were broken-hearted.*
And it was like, "Let's find Baby Lyn. We have to find Baby Lyn!"
I was like, "Wow! — You're really going to look for a stupid doll for my daughter to make her feel good?"
I just thought it was really great.
You got into looking for this doll — seriously — asking everybody — "Have they seen this doll?" — everybody.
And you found her.
And I was like wow! All this for a doll?
And you let my daughter bring her home, and that doll was — the center of her world.
Baby Lyn sat at the table and ate with us.
She was just there, all the time, right up under her arm.
Walking around with her.
She was the show-and-tell doll — every Friday. "This is Baby Lyn."
And when Baby Lyn's face got a little smudge on it, I had to give Baby Lyn a bath.
She was so excited about this doll that it was just like — I guess a part of here came home with us for her — and for me.
I saw a change in my child.
It was something good that came home, that I learned from my daughter and her doll.
Like if she hurt, she pointed to the doll's arm.
Or if a tooth was coming in and hurt, Baby Lyn's mouth "hurt right here."
I thought it was so great — I was learning what's hurting on her, from her doll.

You came over and I was really surprised . . .
You came in my neighborhood.
You weren't afraid.
On a day that I was really, really sick and missed an appointment, you were determined to keep our appointment, no matter what.
*And it was —*OK *— that really felt good that somebody cared enough to come and see us.*
Antricia was running up and down the stairs, excited, saying:
"Oh, Jeree's here, Jeree's here. She has a present! She has a present!"
I said, "Calm down, girl!"
I was really surprised and taken aback that, you know, you came to my neighborhood and to see ***me.***

Marilyn Nolt

And the walls started tumbling down, and I could trust a little bit more.

I was surprised at everything that you did.
Because growing up, for me, nobody was ever there, and — as I said before — I never trusted anybody.
Everything was the opposite of what I thought.
Like when you came over in my neighborhood, it was just — I never thought you would do that.
When you let my daughter have Baby Lyn from the program, I was like, "She would never give this doll away."
And I was like, "Take good care of this doll, you know, we can't get her dirty."
I learned something from my daughter — that it's ok to take what people are giving you, if it is in a good way.
And it's ok if you mess up. It was different..

When you stepped in, it was like, ok, this is something that I really did need.
You were just yourself.
You weren't afraid to speak up and let me know that there are things that I shouldn't be doing.
Most people are afraid to let people know those things. You can't be hitting, you can't be doing this.

Right off the bat — you didn't hold back.
So it was really great that you were honest and you were ***there.***
You had feelings.
It was like a handshake.
It was a strong handshake.
It was real.

I told you once when I was upset and hit my daughter and you just came right out and said, "We can't have that. I ***won't*** *have that."*
And I thought, "What? Excuse me? This is my child. You can't tell me what to do."

(This is all in my mind —like, "No!", you know.)
I was just blown away, it just tickled me.

Wow! She's yelling at me.
It was so cute — it really struck me as funny.
Because you didn't hold your tongue.
Most people — I feel that they're afraid of the consequences . . . they'll stop, and then there will be, "Well, I'm just going to have to take your child from you."

That's not the way to go about it.
It's . . . not helpful.

When you said, "You just can't do that, you know, I won't have it," it was like "OK, wow."
I felt like a three-year-old, but it just felt really good that you weren't afraid to say that to me.
And it was easy to say, "OK, I won't hit her no more."
And I haven't.
Which is good.
Sometimes I really want to just tear her up.
But I've learned — and she's learned — that hitting isn't the way to raise a child.
Now when she's sixteen and wants to do something wrong, I'm going to bring her here and say, "OK, I never hit her. Take care of this situation!"

At first, I couldn't read you.
I couldn't crack you.
No matter what I did, you were there.
You were just hanging on.
And because I didn't trust, I didn't think you liked me.
But once I started to trust in something, it felt comfortable . . .
I did feel that you liked me . . .
It was just me, and the way I was feeling anyway.
It's not what you do, it's how you do it that made a difference.

And I think if you're one of those people that smile in people's faces and then aren't really there for them, no matter how much you smile, you can see under that, no matter how bad you're feeling.
And with you, it wasn't like that.
Everything was real.

I remember one night you took my daughter and me out to dinner, and I was totally blown away.
It was my birthday, too, and I never had a party.
I never celebrated my birthday; it was like just another day.
And here we were going out this night, and it was the day I was born.
It was like a little birthday celebration, and my daughter was there.
She was surprised that a birthday can be so intimate and small.
This birthday made me feel good inside.
I liked it.

That day, you were there after five.
It was like, "Wow, I'm so special!"
It was great . . . it was something I know that you didn't have to do, and I didn't feel that you were making yourself sit here and have dinner, and it just made me feel really special.

Another time I was having a real hard time.
You had come over.
I had called you.
You had given me your home phone number.
I was, like, "OK, she gave me her home phone number. I'm going to use it!"
I was feeling really, really down, and I called you and you came over, even though I knew by your voice that you were —you have your own life, and everything, but you came over, and it was like, "Oh, wow, she's here, she's actually here."
I was basically testing the waters.
I needed somebody with me that day.
You were there.
You really didn't have to be, but you were.

I've been through a lot of programs, and ran into a lot people on the mental health highway, and you run into a lot of people that are just there for the money, if it's money, or whatever it is.
They're not there because they want to be there to help people.
And they're really rude, and nasty.
They don't give a damn about you . . .
They can really build a . . . plexiglass thing between you . . .
It's like...they're at this high desk, and you're at this low desk and chair, and they're looking down on you, and they really make you feel bad.
And it's like — yuck. I don't know if I can trust this person with my life, because they're not really there.
Well, actually I just feel that they should be on the other side of this plexiglass — with me.

You and my other therapist were mother figures for me.
I really didn't know how to raise this little, tiny baby.
I didn't know what to do aside from changing diapers and feeding and burping.
That's not all there's to it.
I didn't know.
With your help . . . for me it felt like having two mother figures help me along with my child.
Not having that from my own family . . .

I feel that if I can raise my child properly, then maybe she'll be a better person to her kid.
It's like breaking the cycle.
I wasn't raised properly, and learning something from you and my therapist helped me to raise my child properly.
Even though I was like 27, 26, hey, I was being raised . . .
You can be raised over, no matter how old you are.

You guys taught me how to love.
You taught me how to speak — speak softly — with a big voice.
You taught me how to care.
And those were things that weren't inside of me.

I think Terry makes the point that certain things that I did and that her therapist did, and how we were, changed the way that she could feel about others and herself. However, let there be no mistake. Untangling and understanding the impact of her history was a job that Terry, her therapist, and I worked very hard at. Still, the impact of how we both were with her played its own vital role and allowed the other work we did to occur.

How had I been? I had tried to be nonjudgmental, respectful, interested, concerned, attentive, practical, reality-testing, and painstaking in building and articulating what the parameters of our relationship were. I was aware of thinking about my own threshold for availability, of slavishly remembering what it was that I was told, and of trying to be honest. I knew that I was never confused about whose responsibility it was to keep the relationship working if it were at all possible. I attempted (but sometimes failed) not to promise more than I could deliver, and we talked about it when she wanted more.

In fact, as always, we developed a personal vocabulary. At the heart of it were two phrases that I said to her

that she came to know the meaning of: "I am always available when I am available" and "I will take care of myself, and I will always tell you if I feel that something is too much. It is not your responsibility to worry about; it is mine."

I met Terry when she was 26 and her daughter Antricia was 14 months old. I saw Terry weekly with her daughter and weekly alone. There were also contacts during crisis periods. Terry had been referred by her individual therapist, and our collaboration was crucially intense and wholly cooperative. In the course of our work, Terry sometimes frightened me and her therapist in regard to herself and her daughter and their safety. This demanded intense collaboration. Fortunately, Terry's therapist and I shared a high tolerance for meeting needs, concern for establishing clear boundaries but great flexibility for what they were. We were both comfortable with the need for the three of us to work together in whatever ways we needed to do so.

Terry now works, has friends, and takes excellent care of her daughter. Antricia is a very delightful child with many friends, doing well in school, and with high ambitions for the future.

Within six months of our beginning to work together, Terry began to speak in various metaphorical and then more direct ways of feeling as if she existed for me and for her therapist. This became an extremely important and overt theme. My major association to the meaning of much of what Terry says is to something I have observed in many, many parents whom I have seen. It relates to a basic understanding of human connectedness. This is singularly relevant, I think, to Terry's experience and inner world when I first saw her.

I recall saying to a young woman with whom I was working many years ago that since our last visit, I had been thinking about something she had said. I then delivered some comment that I blissfully no longer remember. It was totally clear at the time that it made absolutely no impression on her. What was apparent, however, was that she was totally startled that I had thought about her in her absence. She was visibly taken aback, and seemed confusedly pleased, though, after an expression of surprise, she could not really talk about it....not then.What is important about that, what was important about Terry as I first knew her, was that I was observing the absence in this young woman and in Terry of something that is vital to children.

Ten-month-olds — well-functioning, ordinary babies — remember the objects behind them with which they have been playing and, without looking, reach for them with confidence and skill. This concrete image, as well as the cognitive/affective functioning it suggests, always brings to my mind a crucial internal sense that I see develop in infants who receive reasonable care. Babies feel that they exist in their caregivers' minds. The mother who is out of sight behind them is simultaneously holding and organizing them. When a child is held in mind, the child feels it, and knows it. There is a sense of safety, of containment, and, most important, existence in that other, which has always seemed to me vital.

Everyone deserves the experience of existing in someone's mind.

A two-month-old held facing outward will drop his head back to look at the holder from time to time, if he's well nurtured. By the time you are a sitting baby, with good enough ordinary experiences, your very back feels safe, held. You know you are watched — that is, that you exist, are held, in someone's mind. You feel secure, and secured.

But this only develops if you truly are consistently in the mind of someone, so that you are noted, noticed, spoken to over distance, rescued, protected, appreciated, and tethered across space and out of mutual sight. It is the caregiver that creates and confirms this, by her continual surveillance and by holding the child in continual existence in her mind. This becomes a crucial part of a child's internal sense and experience.

There are many children in differing circumstances who are not cared for in this way. Antricia was about to become one of them, and Terry was one of them.

These children are ones we worry about particularly. They are too often like little billiard balls, careening about from someone else's impetus, responding to that impetus, but left wholly on their own and feeling that until the next, unexpected external thrust. This will rarely have anything to do with what they want, or what they need. It is in that sense a nonorganic, episodic, lonely existence, and they are held in no one's mind.

One must worry deeply about this sense of human connectedness in children. It is truly a substrate of the development of mutual concern. Everyone deserves the experience of existing in someone's mind. If a parent cannot provide this, perhaps a special teacher can, a social worker, a great-grandmother. I believe that some potential to create that experience with a person continues to exist over a person's lifetime, though it grows increasingly arduous. I believe that this was created with Terry, and was crucial to her experience and to her growing ability to care, in positive ways, for her daughter and about herself.

It seems to me that one of life's greatest privileges is just that — the experience of being held in someone's mind. Possibly, though, there is one exception — and that is the privilege of holding another in one's own.

"She does love me, doesn't she?"

A story of longing, waiting, and responding

Deborah J. Weatherston, M.A.

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A compassionate nurse practitioner from the Public Health Clinic called an infant mental health specialist to express her concerns about Sally, a two-month-old baby who was enrolled at the public health clinic for pediatric care. The nurse described Sally as "pale and failing to gain." She noted that the birth records reported "a healthy baby girl, delivered 3 weeks before her due date, 6 lbs. 7 oz., 19 inches long, with an Apgar score of 8-9." A robust baby at birth, Sally now appeared "unresponsive and underweight."

Other observations were more worrisome. The nurse practitioner described Sally's mother, Peg, as "inattentive to her baby, disorganized, somewhat depressed." She reported that when Sally whimpered, her mother took a long time to respond. When at last Peg attempted to pick Sally up out of the infant seat, Sally stiffened and turned her head away. The nurse also noticed that there were no smiles between them, and few moments of pleasure or satisfaction. She was understandably worried about Sally's development, Peg's unsuccessful attempts at caregiving, and their relationship, which was clearly at risk. "Can you help them?" she asked the infant mental health specialist. "Can you go out to their home?"

The infant mental health specialist whom the nurse practitioner called was one of three full-time home visitors funded by the local community mental health board to provide in-home services to infants and families at-risk for neglect or abuse. The Michigan Department of Mental Health has developed a network of more than 34 infant mental health programs in rural, suburban, and urban communities across the state. Dedicated to prevention and early intervention, these programs assure that each year more than 1,200 infants and their families, identified as at psychological and social risk, receive home visit services. These services support parents in the early care of their young children, to strengthen developing attachment relationships and to reduce the risks of emotional impairment, developmental failure, and parental abuse or neglect.

Often referred to as "kitchen table therapy" (Fraiberg, 1980), most infant mental health services take place within the intimacy of a parent's home. Infant mental health specialists visit parent(s) and infant together weekly, or more frequently, according to the needs for intervention and support. Some interventions are brief (six weeks to three months) and focused on a specific need or problem — for example, colic, a sleep problem, a feeding difficulty, or temper tantrums. Intervention may also be more complex and long-term, requiring one to several years of service support. In all instances, infant mental health specialists and parents plan for interventions with respect for the parent-child relationship. Home visits provide unique opportunities for the infant mental health specialist to observe and understand what each baby and parent brings to the parent-child relationship, the nature of that relationship, the baby's adaptive capacities, and worries that parents may have about the baby or the relationship. Home visits also provide opportunities for the specialist and parents to consider what makes caregiving so difficult and what support is needed to improve the baby's care. The specialist looks and listens to parents and their infants in effort to understand their dilemmas and provide appropriate support.

When the nurse practitioner called about Sally, the infant mental health specialist suggested that she ask Peg if she would like a visitor to come talk to her at home. A few days later, the nurse called to tell the specialist that Peg was expecting her call. When the specialist reached Peg the next day, she listened to Peg's descriptions of a baby who was "fussy and very hard to feed." The specialist acknowledged that the care of a fussy baby is very difficult and offered to come visit her the next day. Although hesitant about the prospect of a mental health intervention, Peg agreed to let the specialist come to see her and the baby in their home.

First visits

The infant mental health specialist arrived just when she said she would be there, at 2:00 p.m.the next day. A nervous young mother opened the door. Sally was nowhere in sight. Peg asked the infant mental health specialist to sit down at the kitchen table and offered her a cup of coffee. She introduced Bobby, her 18-month-old

Acknowledgments: The author is grateful to the Skillman Foundation for its support for the preparation of this article, and indebted to Kathleen Baltman, William Schafer, and Barry Wright, who provided clinical guidance in abundance and collegial support. Special thanks and recognition are given to Betty Tableman, whose leadership, vision, and courage have assured that the State of Michigan, through the Department of Mental Health, offers infant mental health services to infants, toddlers, and families statewide.

Note: All names and other identifying details have been changed to preserve confidentiality.

son. She seemed very proud of him, quickly describing all that he could do. She pulled him on to her lap and gave him a kiss. "Mama's best boy," she whispered.

Notes from this first visit described Sally:

She was at first left alone in the playpen in the other room, awake, but quiet, making no demands, sucking on her pacifier. When her mother approached her, Sally showed little interest. There was no brightening, no mutual gaze, and no vocalization. Peg picked Sally up and carried her awkwardly across the room. Sally looked equally uncomfortable, avoidant and difficult to engage. Her bottle lay in the crib, sour and half-empty. She was urine-soaked. Peg put Sally on the couch beside her, where the baby lay, staring and unsmiling, as we talked.

What made the care of this baby so difficult? What did Sally bring to her mother that resulted in such inappropriate care? What did Peg bring to her baby that so quickly led to the turning of her head rather than a full and satisfying gaze? What kind of intervention could be constructed that would better assure the mutual pleasure of both parent and child? These, and questions like these, guided the infant mental health specialist's observations in her first visits to their home.

The specialist invited Peg to talk about Sally and the experiences they had had in the first months at home. Peg seemed relived to have someone listen. She agreed to have the specialist come visit again.

The information that follows was gathered after six visits. The specialist visited twice weekly, and stayed for an hour each time she came. Peg always knew when the visit was scheduled, and was most often there. Observations of the baby, knowledge of the family's immediate needs, descriptions of their interactions, and stories shared helped the infant mental health specialist to better understand some of the worries and the risks that this family faced.

The baby's story

Sally was delivered after a long and difficult labor. Her mother described her as "scrawny, not like my first." The youngest of three small children, Sally was Peg's second daughter. The oldest, Chana, was four years old. She lived with her father and rarely saw Peg any more. Sally's brother, 18-month-old Bobby, lived with his mother. Competent at birth, Sally was discharged two days following delivery, experiencing no separation from her mother until three weeks of age, when an apnea episode sent her back to the hospital for observation and an inconclusive report. Peg described her pregnancy as "nothing special," noting, however, that she "never planned to get pregnant so soon, especially not with another girl."

These few observations suggested to the infant mental health specialist that there were many concerns: Peg had not been prepared for the care of another baby. She had "lost" her first child. She felt overburdened by a baby girl.

Peg

Peg, at 24 years of age, was gentle and soft-spoken. Divorced, she lived alone with her children in a small frame home. She was dependent on welfare for support and had no car. Lonely, she seemed to welcome the infant mental health specialist's visits and expressed the wish to "talk to someone who could understand."

In contrast to her handling of Bobby, Peg appeared unable to hold, successfully comfort, or comfortably feed her baby girl. She placed Sally several rooms away during many of the initial home visits, propped the bottle, and appeared ambivalent about her youngest child. There were signs that Sally was not responsive to Peg's voice or gaze. Sober, the baby did not reward her mother with smiles or coos. Instead, she turned her head away, in search of her bottle or pacifier. Peg, in turn, failed to support much interaction, preferring instead to put Sally in the playpen or in the swing, avoiding contact and containing Sally as best she could. The two were clearly avoidant of one another.

The infant mental health specialist's response

The infant mental health specialist left Peg and Sally feeling anxious, lonely and tense herself. The baby's loneliness and absence of pleasure were painful; the mother's needs, her isolation from family and friends, were sorrowful, too. The specialist knew that both needed comfort, nurturance and support. Peg would need to feel well taken care of before she could take good care of Sally. She would have to feel "held" and "fed" before she could hold and feed her infant. The principles of intervention defined so clearly by Selma Fraiberg and her colleagues (Fraiberg, S. et. al, 1980) would be important here:

- Listen and observe carefully in effort to understand.
- Nurture the parent so that she may in turn nurture her baby.
- Attend to both the parent and infant in order to strengthen the early developing attachment relationship.

A plan

These principles helped Peg and the infant mental health specialist to develop a plan: home visits with both Peg and Sally together in their home, two times a week, for one hour each visit. The initial goals were to reduce the continuing risk of failure to thrive, to support Sally's interest in people and playthings, to strengthen Sally's capacities to be more responsive to her mother's care, to support Peg's interest in Sally, to enhance Peg's caregiving skills, and to strengthen the developing relationship between them. The infant mental health specialist understood that these goals called for an ambitious intervention. She would need to use all of the strategies available for service (see sidebar, p. 8): con-

Infant mental health services: Strategies for support

Infant mental health specialists use a range of strategies to strengthen infant and parent capabilities within the context of early developing parent-child relationships. These strategies include emotional support, concrete services, developmental guidance, infant-parent psychotherapy, and advocacy (Weatherston & Tableman, 1989). With respect for strong and stable working relationships, infant mental health specialists offer some or all of these strategies, as appropriate, for each infant and family referred.

Emotional support

An infant mental health specialist may offer emotional support related to an immediate crisis, e.g. the birth of a premature infant, the hospitalization of a baby, the death of a child, the loneliness of a parent who is unprepared for the care of a baby. The specialist looks and listens carefully, acknowledges the family's strengths and needs, and shows compassion for their difficulties. The specialist invites the parent or caregiver to talk about experiences with the baby, careful to follow their lead. She or he offers empathy in response to the crisis, and to the family's need for care. In many instances, it is the specialist's behavior — for example, regular and consistent presence in the home — that communicates concern and support. The specialist's words also offer reassurance, helping to identify troublesome feelings, to define risks, and set limits that are firm, clear, and fair. Actions and words help parents to more successfully nurture their infants and establish relationships that reduce developmental risks.

Concrete resources

Many families referred for infant mental health services have basic needs for food, housing, clothing, and medical care. These needs must be met in order for parents to feed, nurture, and protect their young children. The specialist who sees that a family is hungry helps them to eat and, in turn, to feed their children. By meeting a family's needs for concrete resources, the infant mental health specialist helps parents to survive and care for their infants. Such concrete support serves as a powerful metaphor for ways that the specialist can be helpful to the infant and family, and facilitates the development of a working relationship.

Developmental guidance

The infant mental health specialist may also provide developmental guidance that is specific to each baby's pattern of growth and change, encouraging parental attention, interest, and appropriate response. The specialist offers information about the baby and basic child care routines, e.g. feeding, sleeping, crying, comforting. The specialist encourages parents to look for the baby's changing competencies, suggesting what developmental tasks lie ahead. She encourages activities and experiences that will enrich both the baby's and the parent's pleasures and capabilities. The specialist makes informal observations about the baby and invites a parent to do the same. It may also be appropriate for the specialist to speak for the baby, identifying the baby's immediate wants or needs.

On occasion, the infant mental health specialist may model a particular caregiving behavior, encouraging the baby to respond. However, the specialist is careful to support the parent's capacity to do the same with the baby, as it is the parent-infant relationship that is of importance here, not the relationship between the specialist and child. The specialist may also make playthings available to families, offering opportunities for pleasure where resources are scarce.

Infant-parent psychotherapy

Some families need only support and guidance to successfully strengthen their parenting capacities and support healthy relationships with their infants. Other families need more help in understanding their distress. Infant-parent psychotherapy helps parent(s) to explore thoughts and feelings about the baby, caregiving responsibilities, and relationships. Major clinical concerns may include early or unresolved loss, prolonged separation, maternal deprivation, or trauma leaving physical or emotional scars. Memories attached to difficult past experiences and relationships may be awakened with intensity in the presence of an infant, placing painful burdens on parents as they struggle to provide this infant with care. In protecting themselves from feelings that are aroused, they may shut down, withdraw, lash out, or run away. They place their infants at continuing risk because they cannot hold, comfort, or respond with sensitivity. This of course makes the care of a baby problematic and heightens the risk. The infant mental health specialist explores feelings and behaviors as parents are able to do, in the presence of the infant, and within the context of the trusting working relationship.

Advocacy

Finally, the infant mental health specialist may act as an advocate as needed by parent or infant. The specialist speaks for the baby's need for stable and affectionate care, as well as for the parent's need to care well for the baby. She may go to court on behalf of their right to remain together. She may work within the child welfare system to secure a permanent plan for a baby whose parent cannot provide adequate care. The specialist has continuing responsibility to speak for those who cannot, in settings where decisions are important to healthy attachments.

All of these strategies help infant mental health specialists to support early developing relationships in families. In practice, some or all strategies may be appropriate to the needs of individual infants and families referred for service. Some or all may be interwoven in the course of each home visit.

crete resource support, emotional support, developmental guidance, infant-parent psychotherapy and advocacy.

Meeting needs

The specialist described Peg's home as "crowded, cluttered, disorganized and impoverished." There were so many needs — a crib for Sally, a mattress, an infant seat, clothes, food, formula. The specialist found some of these things; other agencies were generous in response. A donated washing machine was a tangible measure of help for an overburdened mother. The specialist's actions and their concrete results gave evidence of her concern for the family and her ability to be helpful to them.

In the midst of chaos and confusion, the infant mental health specialist met regularly with Sally, Peg, and Bobby. She arrived when she said she would. She proved herself trustworthy and able to listen Peg. She was charged with difficult stories, but was not frightened away. She endured stressful interactions between parent and child and still returned. She listened, as Peg told her — both with words and in her handling of her baby — that Sally's care was difficult for her, and that she wanted that to change. The working relationship between them was forged out of quiet observation, patience, hopefulness, and respect.

Emotional support

The specialist kept a watchful eye on Sally and her mother. She saw that Peg often left Sally for long periods of time in a darkened room, with only a bottle to comfort her cries. Sally, in turn, was difficult to engage. Head turned away, she rarely made eye contact with anyone in the room. She was neither active nor vocal. When she initiated interactions, it was with a whimper, then a cry. She never smiled. She was alternately floppy or stiff and awkward, fists tightly closed and flailing when placed on her back.

After two months of home visits, the infant mental health specialist began to question her careful, nurturing approach. She left the house asking herself, "How long can I wait for Sally to smile? How long can I wait for Peg to pick Sally up and hold her in her arms?" These questions led to an important observation. They were all waiting — Sally, for her mother, and Peg, for Sally's smile. The next week, the specialist returned and watched for an opportunity to describe what she saw. "You have had to wait for a very long time for Sally to look and smile at you. Waiting is not easy." Peg nodded and said, soberly, "I've always had to wait, and not just for her."

Peg began to tell her own painful story of deprivation and early neglect. A particularly poignant tale explained some of her struggle with Sally:

As a very little girl, I remember my mother wore bandages on her hands, both hands. She couldn't touch us or cook for us or pick us up because her hands were covered. She had gotten some kind of rash from a washing compound. So, we moved in with a lady, Jane, who took care of us and cooked for us while my mother got better, but it was a long time to wait. She wore bandages on her hands for many months.

This story was told tearfully, as Peg herself struggled to care for her own baby girl. She could not do what had not been done for her. The specialist commented, "You were very little; you would have wanted your mother to pick you up. You couldn't have understood why she couldn't take care of you then, why you had to wait. You wanted her just as much as Sally now wants you." The story of longing and waiting was told many times, in many ways, with similar response.

A useful drawing

The specialist asked Peg if she could draw a picture of a mother and baby, suggesting that it might be helpful to their work together. A mother-baby drawing underscored what Peg remembered, as well as the present reality with her own child. She drew mother and baby in isolation; there were no eyes and no smiles on either face. Neither one had hands; neither could reach or hold. The infant was drawn in a small playpen, carefully separated from her mother who sat across the room. Stiff, awkward, and unsmiling, both figures reflected longing and estrangement between mother and child.

The specialist asked Peg to tell her about the figures she had drawn. She described the baby, "alone and lonely, just like Sally and just like me." Tearful, she spoke about another mother and baby, offering remembrances that accompanied her own loneliness and despair:

My mother just walked off and left us. She didn't really care. I waited for her to come back.

Sometimes, she beat me for no reason.

When my grandmother died, there wasn't anyone who really cared.

For Peg, the opportunity to talk about painful events within the safety of the therapeutic relationship began to offer some relief. The reminder by the specialist that Sally needed Peg as she had needed her own mother many years ago was significant to the intervention. Peg began to attend more to Sally, to hold her and to feed her with more interest and care.

A visit to the pediatric clinic encouraged everyone. Sally was gaining. At six months of age, three months after home visits had begun, she weighed 14 1/2 pounds. In her notes, the specialist still described Sally as "under-responsive," but she was making better eye contact with her mother, and there were some smiles. She began to show interest in people and playthings. She was more often awake when the specialist arrived and was increasingly responsive to playful games of tickle and peek-a-boo that her mother occasionally initiated.

Marilyn Nolt

Developmental guidance

Within the context of the working relationship, the specialist was able to offer guidance to Peg. She offered information about Sally's development. Peg began to take more pleasure in the gains her daughter made and the milestones she attained: reach, grasp, shake, laugh, roll. The specialist offered careful, supportive direction to Peg's attention to Sally as a separate and competent baby required careful, supportive direction:

She watches you as you cross the room, Peg. She waits for you to come back.

You're becoming important to her now. You're the one who can make her laugh.

She enjoys sitting there on your lap and watching Bobby play.

At seven months, Sally was far more responsive to Peg's fragile overtures of affection and care. The specialist described what she saw and reinforced the abilities of both mother and child.

Clearly, there was an interweaving of strategies throughout the intervention — support, guidance, and relationship-focused psychotherapy. In the months that followed, the specialist continued to help Peg find words to describe difficult experiences of past abuse and gave her permission to express a great deal of anger and pain. The specialist hoped that Peg's angry and sorrowful feelings would not interrupt her capacity to provide more appropriate infant care.

"She loves me, doesn't she?"

Sally grew sturdy and lively. As the home visits continued, she was often clean, dry, and fed when the specialist arrived. Peg sometimes picked Sally up and held her on her lap as she talked about other babies. She compared Sally to Chana, her firstborn baby girl. She remembered holding and feeding her. As the details about that first baby were told, with a depth of sorrow and regret, Peg became more relaxed with Sally. She kissed her and caressed her head. Peg's remembering included stories about the care she had received from her grandmother. She brought out photographs to look at and recalled holidays she had once enjoyed. She remembered songs that her father used to sing. She held Sally in her arms and danced around the room, happy to remember pleasanter times.

When Sally was ten months old, the specialist and Peg reviewed a series of video sequences that they had taken every few months. Peg was able to see that Sally frequently sought her face and voice, clearly turning to her for attention. Peg commented (with amazement, as if she were seeing this for the first time), "She never took her eyes off me!" She reached for Sally and held her on her lap. She asked to see the sequences from beginning to end again. "She does love me, doesn't she? You can see it in her face." In those moments, Peg became the thoughtful observer of her infant, recognizing Sally's longing for maternal attention, as well as her own capacity to care.

This home visit made a remarkable difference in the intervention. After this, Sally was awake and a participant in each visit. She was frequently on her mother's lap or placed to play near her mother's feet. As she grew more mobile, she used her mother as a secure point, from which she crawled to explore interesting surroundings and to which she returned to a smile or reassuring hug. Their relationship, at one time so fragile, became a source of pleasure for both mother and child.

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Using the Principles of Infant-Parent Psychotherapy To Change the Context for Children at Risk

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Will anything I do matter to this family? Most clinicians who provide therapeutic services to families at high environmental and individual risk probably ask themselves this question at one time or another. We wonder how we can expect to deal with psychological issues when a family is using its energy to struggle with poverty, community and familial violence, the vestiges of the drug culture, and other environmental stressors. If there is an opportunity to focus on psychological development, we wonder how to adapt traditional psychotherapeutic methods to meet the complex needs of people whose life circumstances are compounded by individual impairments, such as addiction, cognitive deficits, or severe mental illness.

My relationship with the Queen family helped me to formulate some answers to these questions. I hope that the story of our work together helps others to pose — and to answer — their own questions.

The Queen family: A study in intergenerational maltreatment

The multi-generational nature of the Queen family's difficulties is clearly reflected in their 30-year history as an open case in the protective service system. Velma, the mother with whom we were involved, was the fourth of six children born to an alcoholic mother who abused and neglected her children. Loss was an excessively recurrent theme in the life of this family. Velma spent much of her adolescence in foster care, and she had lost her two older children to the foster care system. Two of Velma's siblings were incarcerated as adolescents. When Velma was a young adult, her mother was murdered; a sister died of a substance abuse-related illness.

Maltreatment defined Velma's relationships with others as a child and as an adult. Her mother abused and neglected her. One of her brothers often attacked her violently; a long scar behind Velma's ear was a concrete reminder of the time her brother stabbed her with a knife. When Velma was an adolescent, her mother's paramour began to abuse her sexually. When her mother died, this man became Velma's paramour and eventually fathered the younger two of her four children. He was quite physically abusive toward her, as he had been with her mother. He often "whipped" her with a belt to force her to comply with his wishes. Ironically, Velma's fear of his violent retaliation helped her refrain from self- and other-destructive tendencies, such as using alcohol, "beating" her children, leaving the children unsupervised, and squandering her public assistance income.

Velma's identity had been forged by adverse circumstances. She had a very poor self-image and was given to emotionally labile and violent outbursts. Her cognitive deficits, particularly in the area of problem-solving, further hindered her capacity to regulate herself. (As an adolescent, she had been diagnosed with mild to moderate mental retardation.) Interestingly, Velma's language and social skills were relatively strong. She was a favorite among support staff wherever she went because she was friendly and verbal, and exhibited a good sense of humor. Her physical health was good, with the exception of a seizure disorder, which was controlled by Dilantin.

Phil and Kristine: A contrast in maternal responsivity

Despite a history of extreme abuse, Velma somehow had retained the capacity to love and nurture. This was most clearly evident in her relationship with Phil, her third child and the first for whom she had been completely responsible. This child was also her most impaired child. During infancy, he had been found to have fetal hydantoin effects due to his mother's use of Dilantin during pregnancy. He had no fingernails, had wide-spaced eyes, and had a flat nasal bridge. At age five, Phil had been diagnosed with moderate to severe mental retardation. He had no expressive language and minimal receptive language, but had better adaptive skills (for example, he was completely toilet-trained).

Velma was completely enamored with this child. She called him her "Sweet-Boy." She was affectionate toward him and quite attuned to his needs. As a result, Phil was quite responsive to his mother. She did not focus on his handicaps at all, and felt that he was developing nicely. In fact, she was quite resistant to sending him to school to address his developmental needs. Velma was afraid of "losing" him.

Note: All names and other identifying details have been changed to preserve confidentiality.

The nurturance that Velma showered on Phil contrasted greatly with her almost complete inaccessibility to Kristine, her fourth and youngest child. When I met Kristine, she was 22 months old. The referral source, staff of a community hospital, had concerns about her progress in every developmental domain. She was consistently weighing below the fifth percentile for no apparent physiological reason and thus had been diagnosed with nonorganic failure to thrive. She had no language and did not exhibit curiosity, problem-solving, or play behavior expectable for her age. There was some concern that her fetal exposure to Dilantin and alcohol, her prematurity, and her current social circumstances were affecting Kristine's cognitive development. Finally, she was an extremely passive child who did not reach out to interact with any adult.

I was immediately struck by Kristine's very flat affect and her tendency to avert her gaze whenever she was approached. She would even place her hand up to her face when approached, as if to ensure that she would not have to interact with the other or to ward off an imminent blow. Her face and gestures evoked images of the children filmed by René Spitz with hospitalism, or anaclitic depression.

Observing Velma's response to Kristine was as alarming as observing the child's affect. She basically ignored this child. She carried and held her five-year-old son, whose growth was not delayed in the least, while her daughter remained in a stroller. Kristine did not protest; it appeared that she had learned that her signals would not be heeded by her mother. Velma did not give Kristine affection or interact with her face-to-face for any purpose. She ensured that her daughter's concrete needs were met, however. For example, Kristine was always dressed appropriately, and was taken to every scheduled medical appointment.

The feeding interaction between Velma and her children reflected most poignantly the disparity in their mother's responsiveness to them. Velma fed both children from one large bowl, with the same spoon. Phil would demand food by grunting and flailing his arms. Velma would quickly thrust the spoon in his mouth. Kristine, who sat unobtrusively at the table, was an afterthought. Every few spoonfuls given to the son would be offset by one spoonful to the daughter, providing her with a disproportionately small amount of the food in the bowl. Thus, Kristine was deprived of both the edible and emotional sustenance her mother was able to provide.

The treatment phase: A lesson in swimming against the tide

The Queen family was referred to our program, which was designed to prevent child abandonment in high risk families, by a community hospital that had been involved with this family for several years. During my first meeting with Velma, she stated vehemently, "I don't want nobody taking my children from me!" With this pronouncement, she steeled herself to wage an anticipated battle over whether she was appropriately mothering her children. Knowing that she had struggled with the child welfare system for many years around this issue, I responded that I knew she loved her children and that our job together would be to help her show her love to each one of them as best she could.

Our therapeutic alliance was based on my acknowledgment that Velma cared for her children and that our mutual goal was to help her children develop as fully as possible. We contracted to meet twice per week indefinitely to accomplish the goals we had set forth. It was a strong alliance, which helped us navigate the difficult terrain ahead — a nearly two-year-long journey, characterized by progress and regress, by solidified and ruptured alliances, and ultimately by growth for all parties involved — including the family members and the professional helpers.

Meeting basic needs

From the very beginning of treatment, the Queen family's need for concrete and tangible nurturance stood out. The family's numerous and complex basic needs offered many opportunities to provide this nurturance. Velma expected me to help her get Kristine into school. (She felt that she could best provide for Phil at home.) She also asked me for help in her negotiations with the social service system, which her cognitive deficits made difficult. My unspoken agenda was to facilitate Kristine's development by helping Velma to be more available to her.

Guided by the therapeutic principle that "you meet a client where she is," I worked with Velma to secure a school placement for her daughter. This represented a strategy to empower the mother by validating what she expressed as a priority. More importantly, it ensured that Kristine would receive some respite from her alternatively unavailable and hostile mother, and that she would experience regular nurturance (edible and emotional sustenance) for perhaps the first time in her life. After considerable advocacy (actually, it was begging, and I would do it again in a minute) we were fortunate to secure a placement for Kristine in an early intervention program with a wonderful combination of classroom staff. The gentle, affectionate teacher became quite attached to Kristine. The teacher's aide, nurturant, albeit in a stern, limit-setting way, became a supportive maternal figure for Velma.

I opted to go more slowly with any placement for Phil, due to the mother's ambivalence about letting him go, more certainty on my part that his emotional needs were being met, and his more complex placement needs.

Heeding Velma's requests for help with the social service system involved spending many hours together in public assistance offices trying to untangle the services

web. Early on, I discovered that Velma was not receiving the full complement of her entitlements; for example, she had not applied for food stamps. I also began accompanying her to medical appointments and discovered that she had not understood vital information, such as her need for glasses and how she could secure them.

In addition to concrete benefits, the hours of waiting also yielded moments in which Velma told me things that became pivotal in our work together. A disturbing revelation that emerged during this phase of the work was that Henry, Phil and Kristine's father (that is, Velma's current paramour and her mother's paramour before her death) had complete control of Velma's money. She turned her welfare check over to him as soon as she received it, and he doled out money to her over the course of the month. On the positive side, I learned that Henry paid every bill on time, so that the family was never in danger of being evicted or of having heat, electricity, or phone service cut off. Nevertheless, I was obviously concerned about what effect this situation had on Velma's sense of psychological well-being and her ability to buy things we thought she needed (like toys for the children) but that Henry didn't. My validation of Velma's feelings of anger and frustration, and her subsequent willingness to explore this issue, presented a natural segue to work that focused on Velma's personal needs.

Hearing a mother's cries

In her classic essay, *Ghosts in the Nursery*, Selma Fraiberg writes of the importance of "hearing a mother's cries" in order to help her "hear her child's cries." Initially, I heard Velma's "cries" of anger and frustration about Henry's control of her money. Then Velma was able to talk about feelings of anger at Henry for controlling her life, for abusing her currently and when she was a child, and for abusing her mother. Velma also felt that Henry had turned her older daughter against her.

Initially, Velma could only ventilate these feelings. Her connection to Henry was profound and steeped in her childhood fantasies about authority and love. Thus, it was only after a year of work on other aspects of herself that Velma was able to consider leaving Henry. She never was able to consider pressing charges against him.

During our two-year relationship, Velma and I addressed many other issues related to her development. I encouraged her to focus on her health and helped her get a thorough physical examination and glasses. When Velma said that she wanted a job so that she could have her own money, I helped her to reconnect to the local vocational rehabilitation program. She attended a training program for several weeks and earned a stipend. She also worked in a cafeteria for a short time, but decided to leave after a physical altercation with another employee.

These experiences, along with steady validation from caring professionals and people in her community, helped boost Velma's self-image considerably. She began to be concerned about her appearance and said that she wanted "to look nice." A woman from her church gave her several high-quality second-hand suits, which she wore regularly.

At one point, Velma decided that she wanted to get a new hairstyle and had a neighborhood woman put braids in her hair. She was very proud of the hairstyle, which made her feel attractive, but when Henry saw the braids, he became angry and beat her, ostensibly because he did not think a woman should wear her hair like that. Velma hurriedly cut the braids out of her hair, leaving her hair uneven and cropped close to her head. This sequence of events was devastating for Velma. Fortunately, she was able to articulate her feelings of outrage to me, and we were able to use this material in our work on her psychological development. Through attention to her concrete needs and through words, I continued to give Velma the message that she was a worthy person.

Velma's descriptions of physical and emotional abuse helped bring the issue of her "ghosts in the nursery" to the foreground of our work. She slowly revealed to me her history of severe maltreatment, including beatings, stabbings, burns, and incest. In many sessions, she recounted her experiences of abuse in excruciating detail; she showed me the scars on her body. Gradually, Velma became able to express the sadness, anger, and fear that she had experienced as a child, and that she was experiencing now, with Henry.

I empathized with the little girl — and with Velma, the grown woman — who had no control over her life, no capacity to protect herself from harm, and nobody to nurture her. I helped Velma see the connections between her abusive past and present, and validated her feelings and her person. That she deserved better and that she now could do something about her life were revelations to her. Slowly, as Velma became more able to express her feelings and wishes for herself, I began to point out to her the connection between her own experiences and those she was inflicting upon Kristine.

Hearing a child's (silent) cries

By the time I met Velma and Kristine, it could no longer be said that this was a mother who did not respond to her daughter's cues. At 22 months, Kristine had long since learned the futility of signaling her mother about any of her needs. Although Kristine blossomed in the early intervention classroom, when she came home she reverted to her passive, frightened, and wary behavior. Over the course of the initial treatment phase, however, I kept trying to help Velma be more attuned to this little girl, to understand her developmental needs, and to attend to her as much as she did to her son. It was the "kitchen therapy" that Fraiberg talks about, watching

for every "teachable" moment that occurs in the course of a home visit to facilitate a mother's insight into her child. There were many moments that might have "taught," but at this stage in our work, most of them went unheeded by Velma.

I began to realize that Velma's home, teeming with people and activity, was not an appropriate place for the kind of interactive work I wanted to do with Velma and Kristine. With home visits retained as a time to focus on larger family issues and concrete needs, Velma contracted to come to the office once a week. While a speech therapist or other professional worked with Phil, she and Kristine would meet with me for one hour for a play session. Thus began a more traditional form of parent-infant psychotherapy.

Sitting and playing with Kristine, even with my support, was overwhelmingly difficult for Velma. She had finally found a place — our relationship — to address her own issues, and was resistant to give this up in order to work with her child. Initially, she agreed to play only for five minutes of the hour. (Constantly looking at her watch to ensure that we had not passed the five minute period, Velma managed to avoid play almost completely.) When she was not avoiding, Velma and her daughter engaged in parallel play, with virtually no interaction between them. When I gently pointed this out, Velma retorted that I should be glad that she was playing at all.

Gradually, I tried to focus on what it felt like for Velma to be playing with her daughter. She began to recount memories of her childhood, when nobody had played with her, and how she felt being ignored by her mother. When I suggested that might be how Kristine felt, Velma registered complete surprise. This exchange began a new phase of the treatment, in which I could ask Velma how she thought Kristine felt about her experiences. She alternated between identifying Kristine's feelings with her own ("She must be sad because I was sad") and denying that Kristine could have the same feelings as she had had ("I don't beat her like I used to get beaten, so she can't be as hurt as I was").

Slowly, as Velma began to recognize and respect what Kristine was feeling, she could offer more of herself to her daughter. She tolerated the play sessions for longer periods and sometimes initiated the interaction with her child. One lovely routine she and Kristine developed together was to dance, holding hands, to music. They were both thrilled with this ritual, and both would collapse in laughter when they were done. Velma was able to transfer this more responsive style to their time at home. She told me, and I observed, that whenever she and Kristine heard up-beat music on a commercial or television program (and the television stayed on most of their time at home), they would jump up and dance together.

While we worked on the mother's and child's interaction at home, I arranged with staff at Kristine's school to focus on mother/daughter interaction in that context as well. Velma went to Kristine's classroom one day a week. Initially, she sat in a corner and watched Kristine go through the routines of the class. She observed her playing, eating, and interacting with the other children and staff. Velma was able to allow Kristine to do the same things at home. This had two positive outcomes. First, instead of forcing Kristine to sit on the sofa all day, Velma allowed her to play on the floor and explore. Second, Velma allowed Kristine to feed herself. And Kristine ate. After about 6 months, she no longer met criteria for failure to thrive and, in fact, became a rather chubby little girl.

As Velma became more invested in and responsive to her daughter, Kristine began to lose her passive, vigilant affect. She frequently smiled at and reached for her mother. I pointed this out to Velma, to help her see how important she was to her daughter. This was very validating to her, given Velma's experiences of rejection in other areas of her life. As she stated poignantly, "Well, at least I know my children love me." As Velma became better able to express her own needs for affection, she often reached out to her daughter with a hug or kiss. Happily, Kristine responded in kind. Velma's and Kristine's "dance" became more and more synchronous, constant, and mutually gratifying.

Although Velma thrived in her new relationship with her daughter, she expressed one serious concern about her growing love for Kristine. Velma feared that she did not have enough love to give to both Phil and Kristine. She was adamant about not depriving Philip of her love — that relationship had sustained her through many difficult times. Although I assured her that she had enough love to give to both children, I was sobered by her revelations and wondered whether she had more insight into her own capacity to give than we did. Although I continued cautiously to foster the closeness between mother and daughter, at the same time, I attended to Velma's conflict about giving to both children, and heeded her reminder that her relationship with Phillip was paramount for her.

A parallel series of events created an interesting twist to the resolution of this issue. I had been working slowly, and with reluctant cooperation from Velma, to get Phillip in school and had finally secured a placement for him around the time that these issues surfaced. Once enrolled in a school that emphasized adaptive skills, Phil quickly learned to feed himself, dress himself, and communicate his needs nonverbally — all of which his mother had done for him before. Velma sadly related that her son no longer needed her as much. Despite my attempts to help her deal with this loss in a more constructive way, Velma resolved the issue by focusing on how much her daughter needed her emotionally and channelling the excess energy she had given to Phillip toward Kristine.

My work with Velma stopped because our program's

funding ended. Clearly, many issues remained unresolved. Yet despite the forced termination, we were able to share our feelings about the relationship we had built and how much Velma had grown as a mother. A year later, meeting Velma by chance in the community hospital, I learned that she had left Henry and moved in with one of her sisters. Watching the physical and emotional connection between Velma and Kristine that day confirmed for me the lasting impact of our work together.

Lessons, values, and principles

The work with the Queen family affirmed for me the value of relying on basic therapeutic principles that transcend theoretical orientation or treatment approach. These principles can be simply stated:

- Relationships are primary.
- A developmental perspective is central to treatment planning.
- Basic concrete needs must be addressed in order for psychological development to occur.
- "Ghosts in the nursery" are real and powerful.

The primacy of relationships

The "holding environment" that I, other program staff, and the school staff created for Velma in many ways challenged the traditional model of the "neutral" psychotherapist. Velma received a clear message of unconditional regard, a sense that she was important to us. Over the course of almost two years I built and solidified a therapeutic alliance with the Queen family. In our first meeting, Velma clearly expressed her mistrust ("I don't want nobody taking my children from me!), but early in our relationship we created a foundation of trust and confidence in each other. Velma began to relate to me as a maternal figure, in whom she confided in and from whom she could request advice about even the smallest decision. As young children do with their parents, Velma internalized the model of the therapist to prevent her from engaging in inappropriate actions. She told me about several occasions on which she wanted to hit one of the children but thought to herself that I would be distressed with her if she did so. These thoughts enabled Velma to inhibit her aggressive impulses: she could separate herself from the child, call me, or use some other containing strategy.

Of course, as Velma began to see me as a maternal figure, I often became the recipient of Velma's hostile feelings toward her mother. At several points, she accused me of trying to take her children from her and trying to be a mother to them. These accusations became understandable when I learned that Velma's two older children, who were in foster care, had been primarily cared for by her own mother when they were with the biological family. Velma also told me that she and her mother would get into violent arguments concerning her ability to care for the children. Thus, Velma's preoccupation with my assessment of her childrearing capacities was rooted in her history of being judged poorly as a parent, first by her mother and then by the social service system.

Given Velma's history of aggression in her relationships, the possibility of a child protection referral was always looming. Velma knew of my legal obligation to report suspected child maltreatment, which had clear implications for the trust and confidentiality contract between us. Although it is tempting to downplay this issue to lessen a client's anxiety, it is a real issue, of which the client is keenly aware. Openness and clarity about the therapist's child protection obligation are essential to therapeutic progress. Velma and I faced the issue squarely, and she understood that my interest was in serving her family and not in reporting.

Countertransference feelings are easily evoked in difficult, complex cases, particularly when a child's safety is at stake. My own anger at Velma for abusing her child was elicited on one occasion, and had the potential to undo a year of painstaking work with this family. After a large multi-family gathering at our program, Velma hit Kristine across the face because she was chasing after a balloon. My immediate response was to chastise Velma for hitting the child. Velma became very angry and sullen and refused to speak to me for the rest of the evening and for several days afterward, despite my entreaties to discuss what had happened and my apology for yelling at her. Finally, Velma responded to my calls and met with me at the office while her children were at school, so that we could focus solely on her. We discussed how she had been criticized by so many people in her life — her mother, brothers, paramour — and how I had caused her to feel the old hurts and anger. I acknowledged her feelings and promised to refrain from yelling at her again. I asked her to help me by letting me know when it felt as if I was like those who had hurt her; I promised to work to change that behavior.

Fortunately, Velma was able to work with me to make our relationship different from others she had experienced. This experience taught her that anger could be handled non-abusively, that she could still be regarded positively despite a transgression, and that her feelings about how she was treated were important. The experience taught me that countertransference feelings can erupt despite experience and knowledge of self. Therapists must engage in constant self-analysis in order to become aware of feelings and avoid acting out these feelings with their clients.

A developmental perspective

Consideration of the developmental functioning of each member of a family is paramount in determining the treatment strategy. In the Queen family, concern about the children's developmental delays prompted the referral for intensive intervention. Since Kristine and Phil were so young, we knew that the major thrust of

psychotherapeutic work would be to change for the better the ecological context, the caregiving environment, in which they were living. We also knew that the children's relationship with their mother was the most important feature of their ecological context.

As I planned a treatment approach, I also had to take into account Phil's and Kristine's distinct positions on the emotional developmental continuum. Phil was a child who had learned to trust, who was not afraid to explore and assert himself. In contrast, at the beginning of treatment, Kristine had not been provided with the emotional scaffold to accomplish any of these things. Without question, she improved greatly over the two years. Although her overall development was still slightly delayed when our intervention ended, she was much closer to age-expected levels and was in a school setting that promoted further growth. Emotionally, she presented as a happy, social child. Because personality development does not have the linear trajectory that cognitive development does, we cannot yet know to what extent Kristine has overcome the trauma of her first two years, and whether she mastered early emotional developmental tasks such as the establishment of trust and autonomy.

Working with a family requires close attention to the developmental issues of adults as well as of children. Assessment of an adult's developmental functioning is needed throughout the treatment process. Making assumptions about a client's capabilities based on an IQ test may deter the therapist from considering potentially fruitful therapeutic endeavors. The referral source described Velma as mentally retarded. Initially, I assumed that insight-oriented therapy, which is generally requires at least average cognitive functioning, would be impossible with her. However, I learned that Velma could articulate her feelings. With a structured approach, rather than the subtle questioning typical of traditional psychotherapy, Velma also became able to make connections between what she felt and what her child felt. Moreover, Velma often surprised me by offering spontaneous insights about her situation. Once she commented: "I just let Henry beat on me just like my mother and brothers did." This statement enabled us to continue to explore her needs in the context of her very volatile, abusive relationship with Henry.

The sensitive, gradual approach used in psychotherapeutic contexts to gain an understanding of a client's emotional functioning can also be used to get a sense of intellectual capacity. It is helpful to be aware of what contexts clients perform best in, what domains of intellectual functioning are strengths, and what coping resources they possess. The more I learned about Velma's capacities, the better I was able to adapt my therapeutic approach to meet her needs. For example, Velma required more than verbal assurances that she had our support. We had to offer consistent, concrete, tangible evidence that she could trust us, and that she would be supported in her drive to create a separate identity for herself.

Attention to complex needs

As the classic needs theory postulated by Maslow suggests, basic needs must be satisfied before psychological development can occur. A traditional psychotherapeutic approach, which offers a client regular, specific time in an office setting to discuss emotional and psychological issues, cannot meet the varied and complex needs of families at high environmental risk. Indeed, the distinction between "case manager" and "therapist" is a useless one for this population. Trust — the essential component of therapeutic relationships — develops when clients can see the tangible results of the efforts that they and the therapist make together.

The delicate balance between meeting the parent's and child's needs has to be attended to, as well. Because current problems in the relationship between parents and children are often rooted in the parents' sense of deprivation, competition between parent and child for the therapist's attention occurs frequently. The therapist must be flexible enough to attend to individual needs while working to strengthen relationships.

Therapists' needs are important, too. The travails of this work should not be minimized. Therapists are forced to contend with issues of personal safety, the intractability of a social system which does not make concrete services accessible to families or workers, the inability to meet some of the family's needs (e.g. move them out of impoverished, violent, drug-infested neighborhoods), burn-out due to the neediness of the families, and very slow rates of progress. When we spend so much of our energy on nurturing families with overwhelming challenges, we also need to nurture ourselves.

Believing in "ghosts"

Velma's "ghosts in the nursery" were potent ones and had thrived in her family for generations. Velma's sense of identity was established through experiences of rejection and brutal violation. Velma had learned her lessons in mothering from a mother who was abusive, neglectful, and plagued by internal and external deficits. Thus, when it was her turn to nurture a child — a child much like herself, an unplanned, unwanted, female child who had come after others had taken what little her mother had to offer — Velma could only give that child the treatment she herself had endured.

However, Velma's story offers testimony that ghosts can be banished and that the impulse to repeat can be harnessed. Recognizing and identifying with a child's feelings can be liberating for a parent. Knowing that you have changed a pattern that has been as painful for yourself as for your child can be very empowering. Becoming aware of your importance in a child's life may not completely compensate for the damages done to

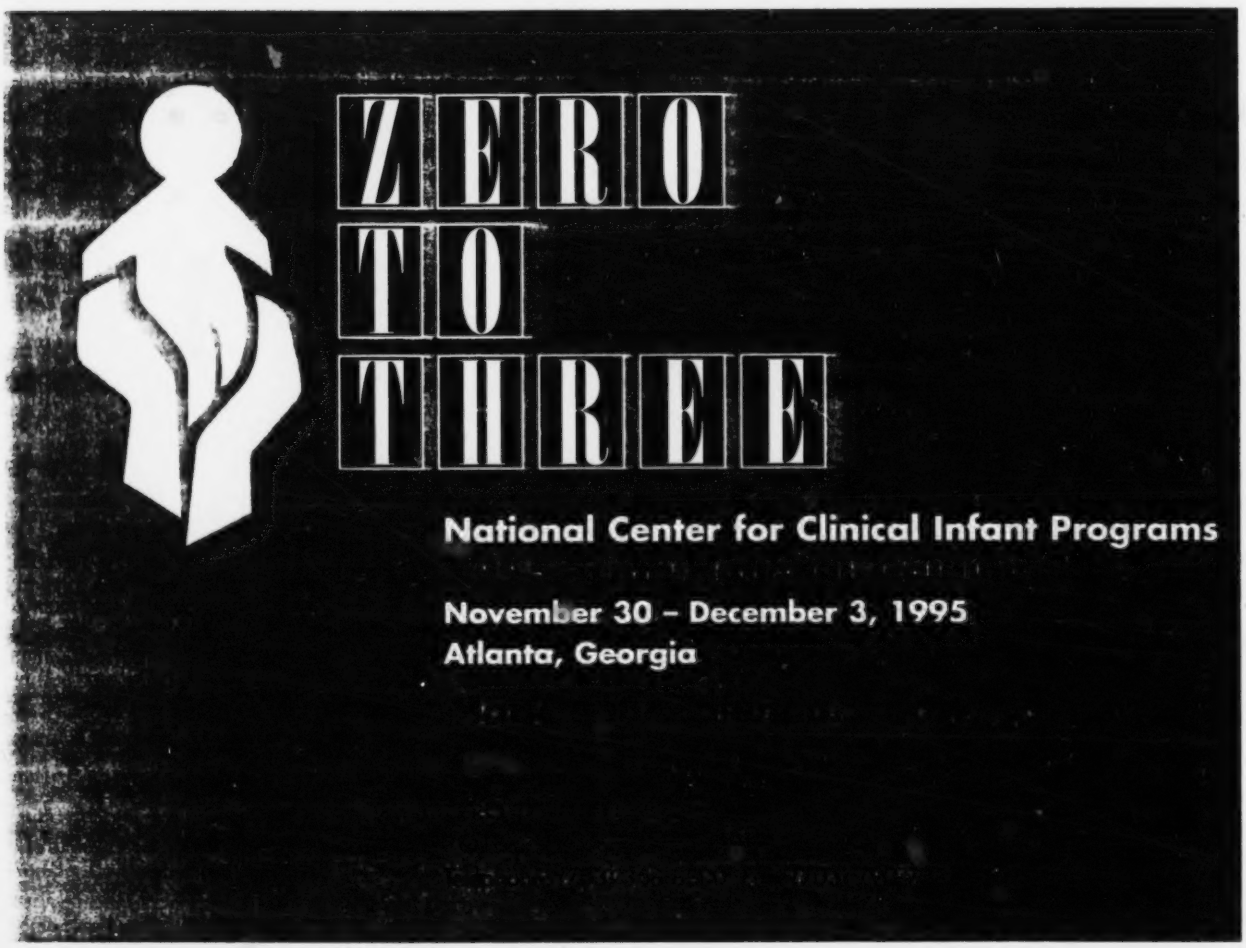
you, but does bolster that part of the self that affirms your worth as a human being.

In conclusion

Parent-infant psychotherapy combines the best of many treatment approaches and techniques, including infant observation, parent education, individual dynamic therapy, and intervention into the family system. The delivery of concrete and case management services focuses on families' basic needs. When one person serves both as "therapist" and "case manager" for families at high environmental risk, she may be able to build a therapeutic alliance strong enough to address all the family's needs — strong enough to make meaningful change in the family's ecological context.

Every parent — even those at highest risk — has strengths, and every parent has the potential to grow. Validating and addressing parents' needs provides them with the psychological resources to be more available and responsive to the needs of their children. Few families will ever be ideal (as if we knew what an "ideal" family is), but "good-enough" mothering can be accomplished.

Parent-infant psychotherapy with high-risk families is an expensive venture. Its intensity makes it a financially costly enterprise. Personal and professional costs for therapists also run high. Despite the expense, it is a treatment approach that can lead to positive outcomes early in the life of a child and parent, even in the most high-risk situations. It is a treatment approach the expense of which must be weighed against the alternatives — leaving children living with the vestiges of generations of familial dysfunction or assigning them to the uncertain fate of being wards of the beleaguered child welfare system. Does what we do matter to families? Yes.



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A Home-Based, Family Systems Approach to the Treatment of African-American Teenage Parents and Their Families

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The issues surrounding teenage pregnancy have captured national attention and concern (Lawson & Rhode, 1993; Musick, 1993). Early clinical approaches to the treatment of teenage mothers tended to focus on the mother-infant dyad and on attachment, bonding and childcare issues (Cherniss, Pawl, & Fraiberg, 1980; Polit & Kahn, 1985; Salguero, Schlesiner, & Yearwood, 1984). Some recent approaches have involved the adolescent parent's family of origin in the treatment process (Cherniss & Herzog, 1986; Moseley & Tatum, 1993; Ooms, 1984; Romig, 1988). The family-centered approach is particularly important with ethnic groups, such as African-Americans, where extended family cultures are prevalent. Thus, family therapists have begun to include multiple generations —grandparents, parents, and children — in the treatment process when appropriate (Boyd-Franklin, 1989; Carver & Herzog, 1993; Hines & Boyd-Franklin, 1982; Moseley & Tatum, 1993).

As the focus has shifted to the engagement of ethnic minority families with a teenage parent, clinicians and family therapists have become concerned about the resistance of many of these clients to entering clinics for services. This resistance is due in large measure to the "healthy cultural suspicion" African-American families have of mental health services (Boyd-Franklin, 1989; Grier & Cobbs, 1968; Hines & Boyd-Franklin, 1982). Therefore, home-based family interventions have been developed as a means of providing quality services to these families (Boyd-Franklin, 1989; Carver & Herzog, 1993; Herzog, Cherniss, & Menzel, 1986; Moseley & Tatum, 1993).

In 1987, with funding from the Office of Adolescent Pregnancy Programs, Office of Population Affairs, DHHS, the CARRI Program at the University of Medicine and Dentistry of New Jersey, Community Mental Health Center in Piscataway began to develop and implement a home-based family therapy program for work with adolescent parents and their extended families. Prior to that time CARRI services were conceived as components of an infant mental health program with an emphasis on the mother-child relationship. However, in 1986 as a result of an evaluation of the effectiveness of program services (Herzog, Cherniss, & Menzel, 1986) the emphasis shifted, first to include grandmothers and ultimately to address the systemic multigenerational family issues and patterns related to the adolescent pregnancy. While the primary goal was to insure the infant's welfare, the hope was to intervene in problematic family patterns in order to improve the health, development and future well-being of all family members. It was hoped that a family-centered approach would result in a more positive environment for everyone, especially the adolescent and her infant.

In order to provide a better understanding of the basis for this home-based family therapy intervention this paper will review first some of the related cultural issues for African-American families and second the intergenerational systemic family issues pertaining to teen pregnancy that are relevant to the African-American experience. These systemic issues include the multigenerational incidence of teen pregnancy and single parenthood, intergenerational role conflict regarding parenting, discontinuities and disruptions in development for both the adolescent and other family members, and the exclusion or absence of consistent male figures. Case material is included to illustrate both the systemic themes and the intervention.

African-American families: The cultural context

Early studies of African-American families were largely pejorative in nature (Moynihan, 1965; Deutsch, 1964; Frazier, 1966), focusing on negative labels such as

Note: All names and other identifying details have been changed to preserve confidentiality.

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"deficit," "disadvantaged," and "deprived." In the last 25 years, a number of scholars have chosen to counter this deficit view by focusing on family strengths, such as strong kinship bonds and extended family ties, strong religious or spiritual orientation, informal adoption, and strong educational and work orientation (Boyd-Franklin, 1989; Billingsley, 1992; Staples, 1994; McAdoo, 1981; Hill, 1972; Billingsley, 1968). The extended family and kinship bonds in African-American families are especially important as they relate to the multigenerational issue of teenage pregnancy and the incorporation of the teenage mother and her baby into her family of origin (Moseley & Tatum, 1993).

Many African-American families have complex extended family households or a closely knit network of households that might include a mother, father, children, grandmother, grandfather, aunts, uncles, and cousins, as well as non-blood relatives such as boyfriends, neighbors, friends, godparents, and, in some cases, members of the "church family," such as a minister, "brothers and sisters in the church," etc. (Boyd-Franklin, 1989; Billingsley, 1992; Staples, 1994). Given this complex network, it is often a serious therapeutic error to focus treatment exclusively on the teenage mother and her baby, ignoring the impact of significant family and extended family members.

Extended family members often play significant roles parenting and rearing the teenage mother and her baby. Given this reality, it is extremely important that therapists working with these teenage mothers and their families identify the key extended family members, the sources of support and strength, the roles of different family members — particularly as they relate to parenting and child rearing — and the sources of conflict as well as role or boundary confusion.

Multigenerational issues of teenage pregnancy, including the role of the infant

Bowen (1976, 1978) identified the concept of the multigenerational transmission process to describe issues that are repeated intergenerationally within a family. For many poor, African-American families, teenage pregnancy is an important aspect of this transmission process (Boyd-Franklin, 1989; Moseley & Tatum, 1993). Genograms (family trees) constructed with families containing a teenage mother frequently reveal that her mother, grandmother and sometimes even a great-grandmother had also been teenage parents.

In some African-American families, feelings of shame and blame surrounding teenage pregnancy are not unusual, and are a typical reaction in families who find themselves repeating patterns of teen pregnancy over generations. It is common for the grandmother and the mother of the adolescent girl to re-experience the feelings they had when the adolescent's mother had been in the same situation as her daughter (Moseley & Tatum, 1993). This theme of repetition is present in the extended case presented below.

These fears and feelings of shame about teen pregnancy may lead to panic and overreaction to adolescent behavior when young girls reach puberty. Such panic may cause overly strict rules to be placed on the daughter — with or without explanation. The daughter, in turn, may respond by becoming even more rebellious. Another unfortunate variation occurs when families adopt a fatalistic stance with regard to adolescent sexual behavior, and essentially give up trying to provide consistent discipline and guidance to the adolescent (Moseley & Tatum, 1993).

Another important intergenerational theme is the sharing of child care among many family members. When the adolescent is not ready to assume full responsibility for her child, other family members will step in, eagerly or with resentment; this process often results in multiple caretakers for a child. A variant of this scenario involves the teenage girl who becomes an "older sibling" to her child, while both are raised by her parents

and/or grandparents in the family home. As the teenage mother grows up, the situation may change, as the family expects her to assume an adult, parental role towards her child, whether or not the child is ready to accept the mother's authority. The Smith family (see below) illustrates the kinds of issues and problems that develop when there is early confusion and conflict in the mothering role.

Given these complex intergenerational dynamics, it is not surprising that the new baby takes on a special significance in many families and may indeed hold different meanings for different members of the same family. In some cases, this child may be a replacement for a child who died or was taken away from the family (Moseley & Tatum, 1993). In other situations, the teenage girl may be "having the baby for her mother," who may never have had the opportunity to parent because she herself was a teenage mother, unable to assume full parental responsibility during her child's early years. In still other cases, the adolescent girl, depressed by the lack of nurturance in her family of origin, may have the baby in order to create someone to love, and to love her. By means of the multigenerational family transmission process (Bowen, 1976; 1978) in all of these situations many issues and attributions can be projected onto the new baby. Unless these attributions are explored and understood, clinicians will be handicapped in the process of facilitating bonding to and nurturance of the new baby.

Although families may be quite angry when they first learn of their teenage daughter's pregnancy, hostility often dissipates by the birth of the baby. Many African-American families truly love and cherish children, and often the entire family lavishes love, presents and attention on the new baby. Frequently, the teenage girl is the indirect beneficiary of this attention and receives presents, baby showers and parties at the time of the birth. When the baby and mother together are positively received, the baby has served a conciliatory role in the family. In other situations, the adolescent girl feels displaced by her own child and resents the direction of family attention towards her baby and away from herself. Whether the new parent feels reunited with her family or displaced by her infant, generational role conflict and confusion is likely to occur over the parenting of the infant.

Intergenerational role conflicts and disruptions in development for the adolescent parent and her family

Traditionally, due to socioeconomic reasons, African-American family members were often forced to take on several roles. For instance, in order to support her family, it was often necessary for a mother to leave her young children with their grandmother while she worked, and the grandmother assumed the role of mother and primary caretaker (Boyd-Franklin, 1989; Moseley & Tatum, 1993). This reality still exists in many African-American families.

The situation is complicated even further by the dilemma created by teenage motherhood. When a teenage girl has a child, she often feels confused and in need of mothering and a mother herself (Moseley & Tatum, 1993). In order for the teen to successfully complete adolescence, she must be allowed to engage in adolescent peer activities and schooling. Some adolescents are too immature to function as a parent. The life of the girl's mother (the baby's grandmother) may be totally disrupted by the birth of the baby as well. Just as this young grandmother is getting ready to focus on developing her own personal goals, she may be forced to assume the care of both her grandchild and her daughter. Normal developmental life stages are thus disrupted for both mother and daughter. If role conflicts which result from this disruption are not resolved, the infant's development is at risk due to inconsistencies in his/her care.

In fact, role confusion is often the presenting problem in families with teenage mothers. With African-American families, the goal of treatment is not to limit the roles to one person of the household, but rather to negotiate roles for the most effective functioning of the whole family, including the care of the infant. For example, in an African-American home there may be a teenage mother, her mother, and her grandmother, as well as other extended family members, all of whom assume some role with the care of the infant. It is important for the therapist to try to understand the family's attitude towards the adolescent and the baby and their expectations in terms of child care. An understanding of these attitudes and expectations must be integrated into the treatment, or various members of the family may sabotage the therapeutic and parent education work with the adolescent parent (Moseley & Tatum, 1993).

Another common conflict which is related to the adolescent's and the family's stage of development centers around issues of dependence and independence. Ideally, during adolescence teens are struggling with independence vs. dependence (McGoldrick, 1982), and parents are beginning to become less involved, allowing their children to move increasingly out of the family system. When an adolescent has a child, conflicts often arise within a family concerning the issue of independence. The adolescent may want to become less dependent, and the adolescent's parents may encourage this independence as well, since the adolescent is now a parent herself. However, the adolescent who is not ready for the responsibilities of parenthood may need to become more dependent on her own parents. Indeed some adolescents seem to use the pregnancy to become more enmeshed with their families, while others use it as a means of separation. It is very difficult for parents and the adolescent parent to successfully negotiate these areas. Family therapy can be the means through

which families work out more effective strategies and satisfying relationships for the benefit of everyone (Moseley & Tatum, 1993).

Key to working out these new strategies is an appreciation for how the birth of a baby to an adolescent may be highly disruptive for the grandparents' lives as well. At this point in the family's life, while adolescents move towards independence parents often focus more on their careers and marriages, as well as on aging parents (McGoldrick, 1982). When an adolescent has a child, this process is impacted severely. Grandparents may have to renegotiate plans for their own lives. A family therapist can be extremely helpful in this process.

The absence or exclusion of fathers

In some African-American families where teen pregnancy is intergenerational, there may also be a history of absence or abandonment by fathers in prior generations. This absence is of serious concern. An evaluation of services provided to teen parents through the CARRI Program (Cherniss & Herzog, 1994) showed that one of the best predictors of good outcomes for teen parents and their infants is the presence of a strong and supportive father figure sometime in the adolescent's childhood. Many of the teen parents with the most successful outcomes, in terms of educational achievement, economic self-sufficiency, and appropriate parenting, reported the presence of a supportive, caring, male figure sometime during their childhood. In the evaluation study, this male figure was not always the natural father; it may have been the grandfather, step-father, uncle, or older cousin. Clearly, programs need to make supporting the presence of positive male figures a primary goal.

The absence of positive male figures may lead to a number of negative consequences in some African-American families with teen parents. Mothers, grandmothers, and great-grandmothers of the teenage girl may harbor intense anger at men and may project that anger onto the baby's father. This situation can create a paradoxical repetition, in which a young father, who may initially want to support his pregnant girlfriend and be involved after the birth of his child, feels excluded, and ultimately withdraws.

This situation may be complicated by the welfare system which encourages the "invisibility" of African-American men by treating them as if they are marginal or peripheral to the family. Franklin (1993) describes the "invisibility" as a cultural paradox, in which high skin color visibility results in fear and leads society to often treat African-American men as if they are "invisible." This invisibility can lead to anger or rage, in African-American men and women alike. It is important for clinicians to be sensitive to this situation and to resist the collusion perpetrated by both the society and some members of the family to perpetuate the invisibility of the male figures. Often fathers, grandfathers, uncles,

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stepfathers, and boyfriends play an important role but are excluded by therapists who accept the family's definition of them as peripheral. It is important for therapists to reach out to men directly through phone, letter, and home visits in order to encourage their participation.

When it is not possible to include male figures directly in the therapy, it is important to help the family recognize that the projection of anger onto the baby's father may in fact be related to unresolved multigenerational issues with other fathers and grandfathers (Moseley & Tatum, 1993). Families need to understand this process so as to avoid excluding the teenage father from contact with the teen mother and his child. In the following case description, the therapists worked directly on including the teen father and on helping the female family members understand how their own negative attitudes towards men affected their treatment of the teen father.

Home-based family-centered treatment

As reviewed above, adolescent parenthood within many African-American families is a reenactment of patterns established in previous generations. This reenactment continues to complicate the life cycle stages of development for the adolescent, for the family as a unit, and ultimately for the infant. Since adolescent parenting can have such an impact on the family, family therapy is often the treatment of choice. This method of treatment allows all individuals in the family system to explore

their feelings and helps to resolve conflicts in the home regarding the impact of the adolescent pregnancy on each member.

When the therapy is provided in the home, it is accessible and more likely to be acceptable to all members of the family. By meeting the family in the home, the therapist is less likely to be associated negatively with a mental health agency. By addressing the family's concrete concerns, such as the medical and educational needs of the pregnant teen, the therapist is seen as someone ready to assist the family in dealing with agencies and professionals which are often experienced by minority families as hostile and unresponsive. By meeting the family in their home and by addressing their most immediate concrete needs, the therapist is more likely to be trusted with the family's most sensitive issues (Moseley & Tatum, 1993).

As the therapist gains the family's trust, she begins to structure periods of open communication among family members. By opening up these lines of communication intergenerational patterns and issues emerge for examination by the whole family. A key ingredient in the delineation of intergenerational patterns is the family's construction of a genogram (see Figure 1). Most families really enjoy this process, which allows them to see for themselves, in an almost pictorial form, the family patterns, especially as they relate to adolescent pregnancy and relationship histories between men and women. The genogram helps the family to talk openly about these patterns and issues and to share their feelings about them (Moseley & Tatum, 1993).

In the CARRI home-based family treatment model, facilitation of communication among family members is the core therapeutic tool. This process is a challenging one, since some African-American families with adolescent mothers have developed ineffective communication patterns from one generation to another. Loud, abrasive language and avoidance may act as substitutes for direct communication including the honest expression of feelings. Some of families have had difficulty expressing their innermost feelings and thoughts, especially when painful issues are addressed. The therapist provides a consistent structure for the exploration of family issues. Through nonintrusive modeling, she teaches the family how to communicate without yelling and screaming. This process makes it possible for families to make more conscious and informed choices about which family patterns they wish to preserve and which they wish to try to change.

Four treatment interventions or considerations have been shown to be essential components of the CARRI model:

1. Home-based services are essential. Since many African-American families are reluctant to seek services in a mental health agency, a therapist will be more likely to engage more members of a household if he brings the service to the home.

2. Genograms or family trees help the therapist and the family identify systemic patterns across generations.

3. The involvement of multiple significant family members across generations is crucial, given the extended family involvement in most African-American families. This process also makes it possible for the therapist to identify those family members who are most able to have a positive effect on the rest of the family — the "kernel(s) of health" described by Minuchin (1984).

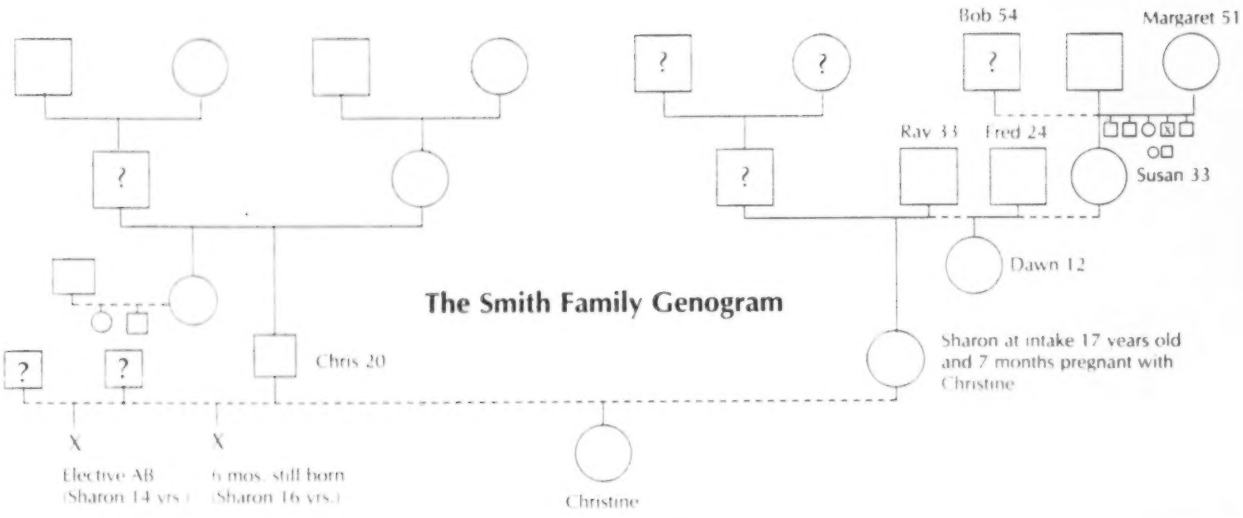
4. Assisting the family in identifying and acquiring concrete services and resources is useful in developing a relationship and in empowering a family to be more self-sufficient. A therapist who supports the family in solving problems around housing, medical care, education, and employment issues is seen as someone who is willing to grapple with their most immediate needs, and therefore as someone who may be trusted.

Our work with the family of Sharon Smith offers an example of home-based, multi-generational family therapy provided by co-therapists. It illustrates a number of the issues common to African-American families with pregnant and parenting adolescents. These issues include problems in family communication and role definition, interruptions in the developmental stages of many members of the family, and repetitions of intergenerational family patterns, including adolescent pregnancies through many generations and male figures who are minimally involved in family life if not totally absent.

Sharon Smith

Sharon Smith, a 17-year-old African-American adolescent, was referred to the CARRI Program for family therapy during her last trimester of pregnancy. At the time of referral, Sharon was living with her maternal grandparents, Mr. and Mrs. Robert and Margaret Smith, and other extended family members in an inner-city apartment. Prior to her pregnancy and for the first five months of her pregnancy, she had lived with her mother Susan, her stepfather Ray, and her half-sister Dawn in a nearby suburb. Conflict between Sharon and her mother had become so intense that she had moved to her grandmother's, as she had at various other difficult times in her life. The grandfather, Mr. Robert Smith, was severely disabled and uninvolved with Sharon's care and with the subsequent therapy. [See Genogram] The grandmother, Mrs. Margaret Smith, was a powerful figure, who dominated the lives of many generations of her family.

Although Sharon was enrolled in an alternative educational program, her attendance had been inconsistent due to her unstable living situation and to medical issues related to her pregnancy. This pregnancy was Sharon's third. At age 14, she



The Smith Family Genogram

had had an elective abortion, and at 16 she had miscarried at six months gestation. Her current pregnancy was considered high-risk due to her health history and to toxemia. The father of Sharon's baby, Chris, was still involved with Sharon, although he was disliked by both her mother and her grandmother and was consistently discouraged from seeing Sharon or from being involved with his child.

The intergenerational themes regarding adolescent parenting and role confusion were immediately evident in this family. Sharon's mother had also been an adolescent parent. Susan had given birth to Sharon at 16. She had wanted to terminate the pregnancy with Sharon, but her own mother had discouraged her from doing so and had been very involved in Sharon's care for the early years of her life. Thus Sharon had initially been cared for primarily by her grandmother while her mother finished school and worked. While she had lived with her mother and step-father for most of her grammar school and adolescent years, Sharon had frequently retreated to her grandmother's in times of family conflict.

Treatment during the pregnancy

The first home-based session included the two therapists, Sharon, Mrs. Margaret Smith, and a cousin who was emotionally supportive to Sharon. Sharon was often intimidated by her grandmother, who was an extremely talkative and forceful individual. In this first session, Sharon and her grandmother agreed that there were many conflicts in the family and that it would be helpful to meet once each week to discuss family problems and to prepare for the infant. Sharon was very nervous about this pregnancy and afraid that she would lose another baby. The grandmother was able to share that she had had several miscarriages herself and understood Sharon's concern. Thus from the first session the therapists facilitated more open and affect-laden communication between Sharon and her grandmother.

Sharon agreed to allow the therapists to refer her to a high-risk prenatal program and to assist her in keeping her appointments. For the next few months the treatment had two functions. The first function was to help Sharon and her family understand and resolve some of their recurring conflicts, so that a more stable and supportive environment could be established for Sharon and her baby. The second function was to insure that Sharon receive the specialized prenatal care that she needed. The focus of this paper is on the family therapy that addressed the first function of treatment. However, it should be understood that the efforts made by the therapists to support Sharon's medical care were seen so positively by both Sharon and her family that these efforts were critical in attaining the trust needed to do the family work.

In the first weeks of treatment, which primarily involved Sharon and Mrs. Margaret Smith, some of the patterns and difficulties in this family became apparent. First of all, Sharon's mother, though invited, failed to come to the sessions, already demonstrating her reluctance to meet with both her own mother and her daughter. Mrs. Margaret Smith dominated the sessions in spite of her granddaughter's attempts to talk. Mrs. Smith was accustomed to telling her family what to do and how to behave. She did not know how to listen. Also, one of the main foci of Mrs. Smith's discourse was extensive criticism of Sharon's boyfriend, Chris, the father of her unborn child. Mrs. Smith had "no use" for Chris; she accused him of not being able or willing to support Sharon. She talked of how the situation reminded her of her daughter (Sharon's mother) Susan's pregnancy with Sharon. This alerted the therapists to an intergenerational or multigenerational transmission process: Mrs. Smith had had "no use" for Sharon's father, either. Sharon acknowledged never knowing her father and having no idea where he is now. With feeling, she said that she wanted **her** child to have a father and so wanted to keep Chris in her life.

In the second month of treatment, Sharon and her grandmother were already acknowledging somewhat improved communication. Mrs. Smith was beginning to listen to Sharon, although she still insisted that Sharon did not listen to her — which really meant that Sharon did not always do what she wanted. For a few sessions, one therapist talked with Mrs. Smith while the other talked alone with Sharon. This gave each an opportunity to tell her own story fully. This strategy was particularly helpful for Sharon, who began to talk more about her

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mother. It was clear by now that it was difficult for Sharon to say positive things about her mother in front of her grandmother, because these two women sometimes competed for the role of chief parent.

Over the next few sessions, Sharon continued to share that she had recently had some more positive contact with her mother and wished to repair that relationship. Although the mother failed to attend therapy sessions, she and Sharon were seeing each other more often and with less accompanying conflict. However, Sharon told of being uncomfortable with her Mom's present boyfriend, who was in his early twenties. The issue of her mother's relationships with men still troubled Sharon greatly.

By the end of the third month of treatment, Sharon was ready to deliver her baby and was planning to move back with her mother after the birth. Although she and her grandmother were much more able to talk and listen to each other, there was some continuing conflict, especially over Chris. Sharon's mother had managed to avoid joining the treatment except around very practical issues, such as planning medical appointments. Finally, in early January, Sharon delivered a healthy full-term baby girl, Christine, and returned home to her mother's apartment.

Sharon becomes a mother

Living with Susan, Sharon, and Christine were Sharon's 12-year-old sister, Dawn, and Susan's young boyfriend. While sessions continued at Susan's apartment, Susan herself was seldom there. Efforts were made to accommodate her work schedule, but there continued to be some resistance to joining the treatment.

Conflict soon erupted in this situation, and Sharon again returned to her grandmother's. For the next few months of treatment, Sharon alternated between these two residences, with her mother caring for the baby when Sharon needed a break. Sharon, who was now close to 19 years of age, began to consider looking for her own place to live. Both her mother and her grandmother objected to Chris, and Sharon felt that with these two strong women so present in her life, she was losing control of her own baby. She wanted to be her child's primary caretaker and did not want to relinquish the care of Christine to either her mother or grandmother. Finding a balance between taking advantage of the support these two offered around the care of the baby and maintaining her own role as mother became a focus of treatment.

While much of the therapy during this interim period was carried out with Sharon alone, the focus of the work was on intergenerational family patterns. These patterns included women relinquishing their roles as mothers to their own mothers and women totally expelling male figures from relationships with their young children. Sharon began to acknowledge that there were some problems with Chris. She wanted him to get a job, and she felt he was not as strongly motivated as she to finish an education. But he did not abuse her, and he did try to maintain a relationship with her and their child. She wanted to continue to give him a chance and to encourage him to get on with education and job training. Sharon and Chris began to look actively for an independent living arrangement. During this whole period, Sharon remained in the alternative educational program and was working on her GED.

A crisis

A period of crisis finally brought all the family issues into clearer focus for everyone. First, Mrs. Smith called one day to report great conflict in her home over Sharon and Chris. In an emergency session, Mrs. Smith shared that she felt she was reliving the earlier situation with her daughter Susan. She said that Sharon's father and Chris were both "dogs" and that she, Mrs. Smith, was reliving the anger and hurt she experienced when her daughter would not "listen" to her. This was pointed out to Mrs. Smith as an example of the intergenerational projection process regarding men.

As Sharon's mother, Susan, began to feel more of the stress of caring for her daughter and her granddaughter she also agreed to join family sessions. A few sessions included Mrs. Smith but most involved Susan alone with her two daughters, Sharon and Dawn. During these sessions, Susan revealed a family secret. She said that she was the only child in her family who had not been fathered by the "grandfather," Mr. Robert Smith. Susan only learned this as an adult, although she had always felt that her parents favored her siblings. When she was little, she had been brought to visit a man who was never identified to her. She believed now that he was her father, although she and her mother had never discussed it. So Susan and Sharon both shared the experience of not knowing their fathers and of feeling left out in their families. Acknowledging this history helped Susan accept Sharon's wish to keep Chris involved in her baby's life.

Another critical issue with which this family began to deal was Susan's lifestyle and its impact on her daughters. The two daughters, Sharon and Dawn, were both very critical of their mother's new young boyfriend and felt she was trying to be an adolescent like them. As Susan began to mourn her own lost adolescence, she recognized the effect her behavior had on her daughters. This also led her to become more responsive to her younger daughter Dawn's emerging adolescent needs. These two began to communicate much more openly and effectively as Susan asserted her wish to care for Dawn in such a way as to prevent another intergenerational repetition of an adolescent pregnancy in this family.

Mother and grandmother

Another important issue on which Susan and Sharon worked was the role of mother. Susan often wanted to take over the care of Christine, although she also resented that responsibility. Susan wanted the experience of finally being a successful parent, but she also wanted to get on with her own life. Ways in which she could support and assist Sharon without taking over were explored. As Susan supported Sharon, she became proud that her daughter could really be a good mother. As she was able to let Sharon separate and be a mother, Susan began to enjoy her role as supportive grandmother. Susan also came to understand that if she took over the care of Christine, the

family cycle would repeat itself, leading to parenting problems in future generations.

At the conclusion of treatment many of these intergenerational issues had been resolved. Role conflicts and communication issues had been addressed. Chris had frequent contact with Christine, who was attached to both her parents and was developing well. Sharon was living on her own and attending school, with her family's encouragement and support. Susan, Sharon and Dawn were communicating openly, and both girls were doing well in school and with their peers.

Discussion

The Smith family illustrates many of the intergenerational themes presented by African-American families with teenage parents. The home-based family therapy approach used in this treatment involved many of the key family and extended family members and allowed for the multi-generational themes to be addressed directly. Many of the family therapy sessions focused on the relationships between the grandmother, the mother, and both daughters. It was clear that the older daughter's pregnancy had evoked memories of prior adolescent pregnancies in the older generations of this family. As these issues were discussed openly in the family, communication between the generations was enhanced; role conflicts regarding the parenting and care of the baby were discussed; and the guilt and angry feelings of the past were separated from present events. The multiple generations of women in the family were helped to see that they were projecting their anger toward men in their past onto the baby's teenage father. The multi-generational family cycle of the exclusion of fathers was broken, as the teen-age father was encouraged to maintain an active role in his child's life. Through this family therapy intervention, the teenage mother was supported by her family in becoming a competent parent living on her own and completing her education.

The Smith family can be seen as a prototype of many African-American families with a history of intergenerational adolescent pregnancy. Their story illustrates the power of the home-based family therapy approach to build trust with families; to address the multi-generational issues directly; and to produce positive change for teenage parents and their children.

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The Interweaving of Neuropsychological Dysfunction and Psychological Conflict

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I am a clinical psychologist with specialty training in neuropsychology. I sought training as a neuropsychologist because I was frequently finding that children perceived by their parents and teachers as having emotional or behavioral problems often also had undetected neurogenic disabilities. Conventional assessment and treatment of such children by psychologists and other mental health professionals has for too long disregarded the possibility of brain-based dysfunction that such children can experience and which in all probability fuels their emotional difficulties. Neuropsychological dysfunction, or a neurogenic disability, refers to a brain-based difficulty or pattern of difficulties which can affect motor, cognitive, memory, language, visual, or sensory systems — in other words, the way a child moves, understands, speaks, thinks, reasons, sees, or senses — and, inevitably, the way a child relates to others and thinks of himself.

In what follows, two cases of young children will be presented to highlight the interweaving of neuropsychological dysfunction and psychological conflict. The parents and teachers of three-year-old Frank called him "aggressive and oppositional." The parents of two-year-old Sara were worried about her "anxious, withdrawn, and bizarre" behavior. The stories of both Frank and Sara — one, a child acting out and aggressive, the other, a child anxious and withdrawn — may help show how a neurogenic disability can masquerade as an emotional problem, be inextricably intertwined with psychological conflict, or be exacerbated by enmeshment in the fantasies and fears of the parents and the particular child-parent interactive system.

Stanley Greenspan, Serena Wieder and others involved with ZERO TO THREE's Diagnostic Classification Task Force have been bringing to awareness the impact that disabilities can have on psychological adjustment and re-thinking diagnostic categories, frameworks for understanding and assessment, and treatment possibilities.* The thinking here is part of the general effort to better comprehend the complex vicissitudes of young children, especially those with hidden or unrecognized constitutional and maturational challenges, or neuropsychological dysfunction. What I hope to do is underline the importance of recognizing a hidden disability and its interweaving with emotional problems. So, besides the cases of Frank and Sara, I will also present some research that documents the frequent concomitance of emotional problems with disabilities. In addition, I will introduce some ways of detecting, by both formal and informal assessment procedures, neuropsychological dysfunction in a child who presents with an emotional or behavioral problem. Finally, I will summarize some neuropsychological underpinnings to commonly encountered emotional or behavioral difficulties, such as those seen in Frank and Sara.

Offered here is a look at an integrated approach to evaluation and treatment that combines neuropsychological assessment procedures with clinical understanding of psychodynamic and family systems issues. This approach emphasizes the relevance of considering neuropsychological contributions to the child's problems while keeping in mind the possible defensive dynamics that can come into play in both the child and the family.

Several themes run through my approach to evaluation and treatment. First, neurogenic disabilities are **subjectively experienced** by any child who has them (even though they may be hidden to others) and taken up into his or her sense of self. They are given meaning and "explanation" by the child, elaborated upon in fantasies, and played out in behavior. This takes place alongside, and in response to, interpretations and reactions to such behaviors, conscious and unconscious, that have been made by family and others. Second, there may be enmeshment of the behaviors in such an interpretive framework so that underlying roots of the difficulties are hidden. The interpretative framework — the meaning given by both the child and others to the child's behavior — can become itself a perpetuating factor in the child's emotional and behavioral problems. Hidden disabilities become overlaid with many issues. Third, the task thus becomes one of **"unbuilding"** — to find the hidden disability in the child and how it has been exacerbated by, or implicated in, psychological conflict, also within a family system. This is done while simultaneously finding the child's key strengths, both to compensate for brain-based difficulties and to build the

Note: All names and other identifying details have been changed to preserve confidentiality.

* Notable is the work by the Diagnostic Classification Task Force, co-chaired by Greenspan and Wieder, on "Regulatory Disorders," a new diagnostic category not offered in DSM III-R or DSM-IV, which includes a range of children all of whom have some form of developmental disability along with emotional issues. The cases that will be discussed in what follows could, in fact, be considered examples of "Regulatory Disorders."

child's self-esteem. Fourth, and a key point, is that to finally detect the underlying hidden disability can result in: 1) circumscribing the weaknesses; 2) damming the spill onto personality structure and family dynamics; and 3) identifying avenues for therapeutic intervention, remediation and growth.

Frank

I first saw three-year-old Frank in his classroom while consulting at the preschool he attended. The Director and his teacher had expressed concerns about his behavior and together with Frank's mother wanted me to observe him first in class.

Although seemingly bright, talkative, and imaginative in his play, Frank repeatedly refused to join in group activities, insisted on being off on his own rather than share or play with other children, and moved around the room like a small bulldozer, knocking into toys and others. When Frank got out of a chair, watch out. "Don't get in my way!" seemed to be the message. Some days he came to class acting like this little bully powerhouse; on other days he was sullen and somewhat withdrawn. Frank seemed to ignore requests made to him, with insistent demands having to be repeated time and again. If you asked Frank to get something in his cubby, he would end up in someone else's. His liking to say "No" appeared as stubborn contrariness, and he easily threw tantrums if his teacher insisted he do things with the rest of the class. He also would grab toys from other children, and hit and bite if the other child protested.

When Mrs. F., Frank's mother, met me at the school, she wore tight-fitting clothes and a great deal of jewelry and make-up. Frank was all over the place, running down the hall. Most of the time his mother didn't seem to notice his whereabouts; if she did, she would embarrassedly tell, while trying to retrieve her son, what "a problem child" Frank was, and blurted out that Frank also bit his cousin, and that he had no sense of remorse. Mrs. F. no longer worked outside the home and couldn't tell me, when I asked, how she spent her time. She appeared depressed.

From the clinical interview with Frank's parents, I had learned that Frank's father came from a family of strong, ambitious, dominant men who "liked their women at home." He worked long hours and was away from the family much of the time. He appeared to hold his wife accountable for Frank's behavior. Mrs. F. said she never wanted to have any more children. She just didn't know how to handle Frank, she confessed. She wanted to hit and bite him back, to teach him not to do it by showing him how it felt.

What's going on with Frank?

Does Frank have a problem related to his mother's depression, his parents' marital difficulties? Is he trying to "rev up" a depressed mother? Or get his mother to sweep him up in her arms and confess, if not her love, at least other strong feelings? Is Frank identifying too much with, and being overly manipulative and controlling like his dad? Are his mother's attributions of "bad boy" and feeling powerless about it, intensified by her feelings toward her husband, fueling Frank's misbehavior? Any or all of these may very well be the case.

But what else is going on with Frank? Is there a hidden disability here that is masquerading as a behavioral problem or fueling emotional and behavioral difficulties that are also rooted in family stresses and tension in the mother-child relationship?

Frank's evaluation results

Generally, the assessment process typically includes one or more clinical interviews with the parents without the child present; observation of the child with the parents; school and home visits, when necessary; and a series of more formal neuropsychological evaluation sessions (where neuropsychological evaluation proper is carried out along with continuing clinical observations of interactions between child and family).

The results of the neuropsychological evaluation revealed that Frank had well-above-average overall cognitive functioning, an attentional deficit disorder (ADD), a mild expressive language problem, and motor planning difficulties.

Later on I will present ways of recognizing elements of Frank's classroom behavior in this neuropsychological profile. For now, keep in mind this example of Frank, and his mother, as one in which there is a mutual exacerbation of neuropsychological dysfunction and psychological conflict that is kept in play, in part, by the ignorance of all concerned to Frank's underlying disability and by the interpretations and misinterpretations made about his behavior.

Sara

In contrast to Frank, who was seen as a child with problems in aggression, Sara was thought of as shy, passive, anxious, and somewhat bizarre. Sara was almost two-and-one-half years old when her parents requested an evaluation. At the initial consultation, Mrs. S., Sara's mother, described her as extremely irritable, anxious, and unhappy — 24 hours a day. She was vulnerable to ear infections and allergies, and was often sick. She threw sustained temper tantrums daily, with her mother's efforts to console and control her fruitless. She was said to have a better relationship with her father and with strangers than with her mother and to be very different in public than she was at home. Sara's mother thought of her as having up/down swings: Cheerful, active, engaging with others; clingy, dependent, and miserable at home. She always awoke from sleep crying. Mrs. S. was also worried that Sara was "unusually repetitive," in play and in focus: Once concerned about something, for example her father going to work, she

would repeat insistently, imploringly, and seemingly unendingly, "Daddy work? Daddy work? Daddy work?" Also, on occasion, she would interrupt an activity and carry on a conversation by herself as if she were talking to someone; sometimes while doing so she would become very anxious and start to cry. Mrs. S. also described some peculiar habits; for example, she would try to soothe herself by stroking an adult's arm or by putting an adult's "elbow in her eye socket." She was said to play with small dolls and was attached to a stuffed bunny.

Sara had a younger sister 6 months old, who, by contrast, was described as easy-going and happy. It was, in fact, the difference noted between her and her sibling that, in part, was responsible for the parents seeking an evaluation.

Sara's teachers at school thought of her as shy, passive, and in her own world. She never had tantrums at school (but neither was she outgoing and engaging). She would, however, tune out and daydream a lot. Although she was said to show a desire to play with other children, she had a hard time with turn taking and extended interactions. She appeared overly involved in her own play, so that if someone said something to her, it was at times like talking to a blank wall. Although symbolic, Sara's play lacked elaborate or extended play schemas. She particularly disliked playing on any playground equipment and did not participate in singing songs at circle time.

Sara could be very verbal, even loquacious, and had an extensive vocabulary, especially for a two-year-old. She could repeat many things that had been said to her and remember them for quite some time — complicated expressions such as, "Mommy is a wife, Daddy is a husband" or ask "Had a good time skiing in Colorado?" to her teacher after a vacation, with her mother's prompting. Often, however, Sara would insert expressions into verbal exchanges at inappropriate times. She could appear internally preoccupied while talking to herself in extended "monologues," using language almost like a transitional object to play with by herself. She showed inconsistent eye contact and limited attention span, and her teacher was very concerned about her peculiar and withdrawn behaviors.

So, what's going on with Sara?

Before I describe the results of the evaluation, I want to describe Sara's parents. Both appear to be sensitive, educated, and articulate, but have a loaded history and not slight leanings to illogical thinking. Sara's father has an aunt with schizophrenia and a grandmother who had manic-depressive illness. Sara's mother came from what she described as a chaotic, dysfunctional family. She had four younger brothers, all of whom had learning disabilities; one suffered from a sleep seizure disorder. In addition, one of the brothers had a substance abuse problem and another had abused a child.

Mrs. S. is the only one in her family who completed college and "made something of herself." She has a degree in literature and fine arts and teaches music at a top Ivy League college. She is a highly verbal woman who, in fact, talks excessively. Before marrying Mr. S., she had several relationships with men, all of whom she saw as being "diametrically different from her" because they came from "good family backgrounds." One was a diplomat in the foreign service. Mr. S. "shares more of her background" than these others.

Like Sara, Mrs. S. has a history of heightened susceptibility to physical illness, and presently has allergies, ulcers, and a hiatal hernia. She feels that her illnesses are exaggerated by stress. She said that she developed ulcers after Sara's birth and after having had an argument with her mother. (Her mother, too, was quite sickly, and as a one-year-old was even given up by her own mother to a relative because of her sickliness.) Mrs. S. complains that her mother was never able to meet her needs but constantly required Mrs. S. to cater to **her**, to listen to **her** problems, and to take charge of the boys for **her**.

Although Mrs. S. felt she had never been listened to, encouraged, or understood, and that everything she has since obtained for herself was in contradistinction to her family and her family's expectations of her, she says she is not angry. She doesn't want to be angry. She feels, instead, sorry for her mother and speaks to her often on the phone. Her mother continues to be unsupportive and even resentful of Mrs. S.'s new values and her moving away from their small southern town. If Mrs. S. comments on her brothers' behaviors or any of the family's "irrational" doings to her mother, she is told that she is selfish and judgmental and that she should be ashamed to talk about her own family like that.

Since adolescence, Mrs. S. has had repeated bouts of depression. She also describes a serious post-partum depression after Sara was born that lasted for almost a year. She describes Sara as "not bonding with her," "straining away from her" and averting her gaze. "In the beginning," Mrs. S. said, "she stared at me constantly, but I would always fall asleep and she would avoid eye contact after that." She openly interpreted Sara's behavior as angry and rejecting of her from the beginning on.

I asked Mr. and Mrs. S. about their "theories" of what was the matter with Sara. Both saw in her the threatened resurgence of bad genes. They feared that she might develop schizophrenia or manic-depressive illness, like Mr. S.'s side of the family. And, indeed, in their initial descriptions of Sara, she seemed on the way. Mrs. S. was also frightened by Sara's possible resemblance to her dysfunctional brothers. Was Sara brain-damaged? Did she have a sleep seizure disorder? What was neurologically the matter with her? Mrs. S., in particular, appeared alienated from her daughter.

Mrs. S. also felt responsible for the way Sara was: If it

wasn't her genes and her post-partum depression that were to blame, it was what she had done prenatally. Mrs. S. had been hospitalized during the first trimester for intestinal problems and had wanted to abort the fetus, which she feared was already damaged from her constant vomiting and medical treatment.

Mrs. S.'s fantasy about having a child was of a baby who would amuse herself in a playpen while she played music. Her second child was that kind of baby, but not Sara. Her fantasy, in other words, was of a baby **who would let her be.** Instead Sara became the clinging, needy, dependent child — just as Mrs. S.'s mother had been. The anger toward her mother, which Mrs. D. denied, seemed to be displaced onto Sara. Mrs. S. wanted to distance herself and turn away from this child, who was a reminder to her of all the dysfunctional aspects of her family (and possibly of herself) that she was so ardently striving to disidentify from. So she focused on the mismatch between herself and her daughter, and on Sara's preference for others.

Sara's evaluation results

When I met Sara, she appeared — contrary to expectations — to be highly curious and to take pleasure in interactions with others, with each of her parents as well as with me. (As mentioned, the evaluation always includes at least one of the parents.) Play with Mrs. S. appeared less focused than with Mr. S. — but, then again, during the evaluation, Mrs. S. was either talking incessantly to Sara, or, as was yet more often the case, to me; she could hardly focus on Sara.

Sara showed good non-verbal skills, especially memory skills, and was skillful in figuring out how all the new toys in my office worked. She also showed a creative bent in her symbolic play, which she enjoyed all the more when it was interactive and when affect was intensified. For example, after a peek-a-boo game that she initiated, she gleefully initiated another such game with a tent-like test booklet (from the Stanford-Binet) which she called a "tunnel." After I admired her action with joyful laughter, she then put an empty box on her head and smiled broadly, calling it a "hat."

The results of the neuropsychological evaluation showed that Sara was a child of above average intelligence who had a developmental language disorder (DLD) of the semantic pragmatic type. Characteristic of Sara, and this type of DLD, is a large discrepancy between receptive and expressive language abilities, with expressive much better than receptive. On a formal language measure, for example, (the Zimmerman Preschool Language Scale), Sara had a receptive language score at the 12th percentile, in the low average range; an expressive language score at the 61st percentile, solidly average. Also characteristic of this kind of DLD, and part of Sara's profile, is excellent rote verbal memory — that is, the ability to repeat long strings of words without necessarily processing their content. These features — good expressive language, large vocabulary, and good rote verbal memory — **give** others the **misleading** impression that the child can understand much more than she can. Receptive language processing is in reality an unreliable channel, making such a child likely to be non-responsive to verbal commands. In this type of semantic pragmatic disorder, moreover, pragmatics — that is, the ability to maintain a verbal topic or non-verbal interaction, or to be appropriately responsive (and so be able to close numerous circles of communication), is also characteristically **weak**. The inept pragmatics that is typically part of this DLD picture usually has at its source both receptive language difficulties and serious organizational/attentional problems, so the child easily gets side-tracked and goes off on tangents. This was the case with Sara.

During the assessment, Sara's organizational and attentional difficulties showed up also in her being self-directed and in the difficult time she had shifting her attention. She could be, on the one hand, overly absorbed or perseveratively stuck in something, or, on the other hand, highly distractible and disorganized, with loss of attentional focus. Her activity level and mood appeared to change depending on the amount and kinds of materials used. The more multisensory, verbal, or numerous the materials were, the more she reacted with increased activity, unfocused regard, and a tendency to tune out. In interactions with Mrs. S., this behavior was more typical than not, but again, Mrs. S. was constantly verbal with Sara.

By history Sara had sensory integration problems, with hypersensitivities (especially to sounds) and fussiness until she was about one year old. Not only was she hypersensitive to her mother's music playing, but also to sirens outside and to the lullabies of her overhead mobile. Consistent with such hyperreactivity is Sara's continuing pattern of disorganizing and withdrawing from too much stimulation. A child with sensory integration difficulties can be easily overstimulated and find modulation of negative states and tension difficult. Such a child may also "learn" to be less reactive to others — or even avoidant of others — as a form of coping.

Sara also showed low motor tone and gestural and motor praxis weaknesses (difficulty imitating complex, sequenced gestures or responding to verbal requests to move in a certain way). This could account for her difficulties on the playground and in participating in circle time singing.

Finally, Sara showed affect sensitivity problems, that is, difficulty reading affective cues, whether presented visually or vocally. Given the importance of affect sensitivity to early reciprocal social interactions between parent and child, it is not surprising that Sara's mother found her daughter unresponsive and difficult to regulate. Affective processing is known to be important for the development of affect tolerance and affect modulation. For example, mothers are known to modulate and

transform their babies' negative affect, as well as increase optimal levels of positive arousal, through their own exaggerated facial and vocal displays. In order for this to work, however, the child must be able to pick up the affective signals communicated to it vocally, gesturally, facially, cross-modally. If not, the child can experience increased negative affect and tension, with poor coping and poor modulation, not to speak of avenues of healthy self-esteem and narcissism, of feeling admired by mother and responding in turn, going awry. Being able to read another's affective expression is also important for "disambiguating the world" — for understanding when a situation is really frightening, and so for alleviating confusion and anxieties.

Given this neuropsychological profile, many of Sara's emotional difficulties could be better understood. What Mrs. S. had not known was, importantly, that Sara had a hard time receptively processing her verbal input to her and that, more generally, she had a difficult time regulating different kinds of sensory input and was so easily overstimulated. Although Mrs. S. was aware, for example, of Sara's sound sensitivities and, of course, of her early fussiness, she had not understood her hypersensitivity to too much stimulation. Thus, in an effort to be a better mother than her own, and feeling guilty about her depressive withdrawal, she tried to provide her daughter with the cognitive stimulation she never got: So, besides talking to her a lot, she surrounded her with "infant-stimulation" paraphernalia, dumping lots of black-and-white-striped objects and toys in her crib. The effects on Sara were to catapult her into disorganization and heightened periods of negative tension. This state of being so easily overwhelmed can adversely affect the development of signal anxiety (e.g., anxiety that warns and elicits coping defenses), which in turn can make the child yet more prone to disorganizing diffuse anxiety states.

What Mrs. S. also had not known was how difficult it is for hyperreactive children like Sara, who also have weaknesses reading affect, to be regulated by their parents or to self-calm — and that they typically tend to avert eye gaze and resist being held. These are typical early forms of coping with too much stimulation, not rejection. But such behaviors can make a mother — especially one vulnerable to depression — feel rejected, and can lead her to project onto the child negative motives so that she ends up believing the baby actively dislikes her. The already poor quality of mutual regulation is then likely to become even worse.

Sara's story illustrates how neuropsychological dysfunction can become interpreted and enmeshed in the fantasies and fears of parents and play havoc in the parent-child interactive system very early on. It highlights the impact of constitutional or neuropsychological factors on the parent-infant interaction. Here vulnerabilities and challenges in the child set in motion or escalate psychic conflict in the parent and rebound back again to affect the child's cognitive growth and personality development. The neuropsychologically vulnerable child puts a hard developmental task onto any parent; for a parent with her own baggage, it is that much more difficult. The results, in Sara, were a compounding and exacerbation of those behaviors that had a neurogenic basis (such as perseveration, distractibility, and disorganization) and a twinning of them to heightened anxieties, and poor coping and social skills.

Clues to use for assessing the "hidden" disability

The stories of Frank and Sara illustrate the importance of considering the possibility that neurogenic conditions may underlie young children's emotional problems. Research, in fact, confirms that developmental disabili-

Research Findings

Developmental disabilities and emotional problems often go hand in hand. Thus the stories of Frank and Sara are, in this respect, not unusual. Research shows a 15% risk for psychiatric problems in the general population for preschool-aged children (Stevenson & Richman) vs. around 50% for children with developmental language disorders (DLD). The latter research includes studies by Cantwell and Baker (600 children, aged 2-15 years), with a diagnosable psychiatric disorder found in 50 percent of the group; by Beitchman (142 children, aged 5) with psychiatric disorders in 48.7% of the group; and by myself (82 children, aged 3-5) with social and emotional problems in 54.4% of the group. Research on DLD, as one kind of neuropsychological disability, is cited not merely because both Frank and Sara had DLD but, more generally, because DLD is one of the disabilities that is very often "hidden," especially during early childhood. What these studies all document is that a very high percentage of children with DLD, even as young as 2 years old, have coexisting emotional and behavioral problems.

Cantwell and Baker reported, interestingly, that the types of emotional problems shown by children with DLD were as diverse as those shown in the general population. These could be categorized as externalizing types of problems (aggressive, oppositional disorders) and internalizing types of problems (anxieties, depression).

In my own study, the important variable that seemed to determine whether a child with a language disorder was at risk for an emotional problem was the child's type of neuropsychological profile.[2] Children with receptive disorders showed more emotional difficulties than children with expressive disorders; and they showed more internalizing types of problems. Also, among children with receptive disorders, those with affect sensitivity problems were especially vulnerable. One particular neuropsychological subtype of receptives, those with semantic pragmatic DLD, such as Sara showed, tended to have the most severe emotional disturbance.

Neuropsychological Functions

Organizational and executive functions:
- Vigilance and selective attention
- Mental tracking and flexibility
- Dynamic motor coordination

Language-related functions:
- Auditory processing
- Phonological production and speech
- Auditory cognitive functions
- Language comprehension and expression

Memory functions:
- Verbal memory and word retrieval
- Visual memory

Visual-related functions:
- Visual-perceptual processing
- Visual cognitive functions
- Visual spatial functions

Sensory-perceptual functions:
- Auditory/visual/tactile perception
- Finger gnosis and stereognosis

Motor functions:
- Fine and gross motor coordination
- Graphomotor functions
- Oromotor functions
- Motor tone, motor planning and praxis

Notes on Neuropsychological Assessment

Neuropsychological assessment is necessarily comprehensive in the breadth of functions assessed. It is inherently developmental, incorporating knowledge of brain development as well as developmental expectations across all functions. It is also inherently transdisciplinary, with understanding necessary, for example, of language disorders, movement disorders, neurological syndromes, etc. Its procedures include both formal and informal methods that are intended to tap into targeted skill areas, whether or not a normed test is available. An important advantage, however, to using formal, normed measures is the ability to generate a more precise picture of **intra-individual** differences in the child. These discrepancies in skills can be crucial for disclosing patterns of relative strengths and inefficiencies and a characteristic neuropsychological profile known to be reflective of a disability.

Yet, also critical to a neuropsychological evaluation is analysis of the component skills necessary to perform any given task. Most formal tests tap into multiple functions; in everyday life activities are inherently complex. Thus, it is vital to ask not merely what a child scores or does but, importantly, how he achieved that score or performance. It is the how that reveals what component skills a child may have or lack, or what avenues of compensation he may naturally bring to bear or can be taught to use.

Every assessment must ask how a child achieved, or failed to achieve, a performance. It thus essentially involves modifications of tests and standardized procedures in order to elicit the child's optimal performance potential and adjust for any handicapping condition. It is, in fact, through reiterated testing of hypotheses about what skill areas are affected that intervention strategies are discovered and hidden strengths found.

ties and emotional problems often go hand in hand. (See Research Findings, page 30.) The high frequency of the association makes it all the more pressing to explicitly ask whether a hidden disability may also be involved when a child has a social-emotional problem. So, if it becomes incumbent to raise it as a possibility, how do you go about recognizing flags and features of a hidden neurogenic condition? How do you unbuild to get at the underlying disability?

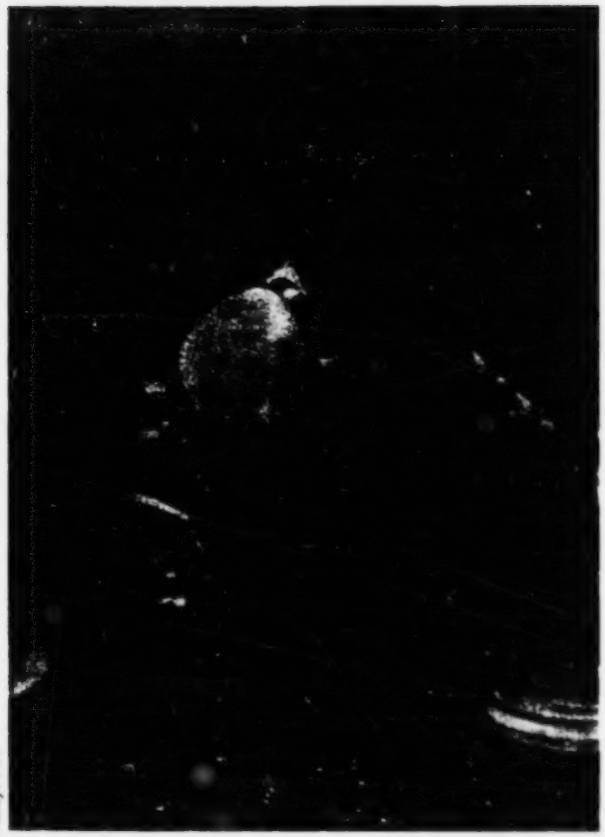
In what follows, a few aspects of a neuropsychological approach to assessment will be sketched along with a sampling of some clues to use to detect neuropsychological dysfunction.

The targeted skills listed (see Neuropsychological Functions, above) stems from **neuropsychological assessment of brain functions** known to be affected in developmental disabilities of various kinds as well as in neurological conditions. They are skill areas that refer to different systems and subsystems in the brain with a neuropsychological evaluation seeking to find out whether consistent, known clusters or patterns of functioning within these different areas are conjointly affected (see also Notes on Neuropsychological Functions, above). This list gives examples of functions assessed; it is not exhaustive.

Here I can focus on only one of these skill areas. Because of its general importance for neurogenic conditions as well as its relevance for both Frank and Sara, it may be useful to look at **organizational or executive functions,** an area which also includes attentional skills.

Organizational and executive functions

These skills are concerned with the regulation and organization of behavior and thinking at all levels, automatic and reflective — from automatic regulation of motor movements to being able to reflectively step back and critically evaluate what you're doing. Called "executive" and, in fact, comparable to "upper management" of a large organization, these functions correspond in the brain to the frontal lobe, that part of the brain that is most characteristic of humans, and that takes the lead, is on "top of" many other functions. It is also called the



Marilyn Nolt

"brain's brain" and is "supramodal." The frontal lobe is connected to many other parts of the brain through complicated fiber networks, so if other areas of the brain are affected, in many cases the frontal lobe will be, as well. These connections explain, in part, why attentional difficulties are so often co-present with many other forms of disabilities.

Organizational and executive functions include:

- functioning in an organized, systematic fashion;
- planning/anticipating vs. acting impulsively;
- keeping track simultaneously of different trains of thought as well as input from different modalities
- initiating, shifting, sustaining attention;
- inhibiting distractions, whether internal or external;
- monitoring and checking one's own activities; and
- using past and future to guide behavior.

Organized, systematic functioning, can affect different and multiple levels, spanning, for example, motor functions, visual functions, and attention, as well as higher order processes such as play, problem solving, and even cognitive style. The following clues can be used in a formal evaluation as well as informally, to guide your focus when observing a child anywhere.

Motor Functions: Look at how smooth and coordinated the child's movements are. A child with problems here can show impulsive movements. With Frank, this was a major factor in his behavior in the classroom. Frank showed poor motor planning and sequencing of movements. When Frank got up out of a chair, he first elbowed his way out in a jerky, staccato way, bumping into the chair and anyone else nearby. Children with ADD often are impulsive. Most of the time, people look at impulsivity in actions and style (interrupting, acting without first thinking of consequences). But many children with ADD, like Frank, show impulsivity in their movements too, because the same area of the brain can be involved. The combination of impulsive movements and impulsive style can be a sure signal that ADD is present.

Visual search: Look at how organized and smooth the child's visual search is. Can the child find things easily, can the child select the **relevant, essential details** easily? When Frank was asked to get something from his cubby he would end up in someone else's. If you watched Frank look for his cubby, if you watched his eye movements, you would see disorganized, random darting here too. Both Frank and Sara showed problems when formally assessed. Although Sara's fine motor coordination was good, if you asked her to place pegs in a pegboard (on the Bayley), she showed a scattered, non-systematic approach, putting pegs in randomly and taking them out again. If you asked either Frank or Sara to find a "hidden figure" (e.g., on the ITPA Visual Closure Test), they couldn't do it. Their difficulties were not related to visual problems, but to disorganized, haphazard scanning. With Frank, this corresponds to the lack of fluidity in his overall motor movements. Informally, in everyday life, watch the way a child looks at pictures in a book or searches for something among things lined up in a row.

Mental tracking and integration of input: What about the child's ability to keep track simultaneously of two different trains of thought or commands as well as input from different modalities? This is called mental tracking and makes use of working memory as well as the ability to flexibly shift attention and integrate information. Think of Sara here, who really couldn't function if too much input from different modalities was given to her at the same time. Sara was hypersensitive not only to noises but also across both auditory and visual input and, especially, in the integration of input simultaneously from both modalities. For example, (on the Bayley) if given a number of objects to discriminate ("show me a plate," "cup," "box"), she could identify the first item asked for (a plate) but then, instead of responding to repeated directives to identify the other objects, she proceeded to play a feeding game with them. Thus, distracted by the toys, she appeared self-directed and unable to simultaneously cue into any verbal input, although the particular verbal commands here were ones she could comprehend and respond to if delivered without as many visual manipulatives.

Attention: You can ask about other specific features of attention such as the ability to **initiate, shift, inhibit, and sustain attention.** How difficult is it for the child to **start** a new activity, to **initiate** a conversation? How difficult is it for you to elicit the child's attention, to ease the child into a command or activity when the child has been absorbed in another task; that is, to **shift** or **switch** his or her attention? What is the child's reactions to transitions, to new activities? Think about whether Frank was intentionally not responding to his teacher or whether he was having a difficult time shifting his attention from what he was doing. Think about Sara's perseverative tendencies and inability to shift out of an activity, a thought, a mood state. On formal tasks that had no great dynamic or emotional import, Sara showed real difficulties in shifting attention: She could not shift to draw a vertical line after drawing a horizontal one (Bayley), but just repeated the same horizontal strokes. Or, on another task (McCarthy Draw-a-Design), she could draw the first design asked for, a much harder-to-draw circle, but then could not shift to draw the simpler horizontal line, which of course she was able to do. Also ask if the child is able to **inhibit** distractions, whether external (noises, sights) or internal (daydreams, bodily sensations). Ask whether the child can sustain attention (which does not mean being glued to the TV, but, rather, being able to follow through with variation and flexibility in attentional focus.)

Play: Look at play and at whether the child spontaneously categorizes, structures, organizes it. Is there an elaborated "sequence" of activities using objects or themes that "belong together"? Or does a random quality infect the child's play? Does the child respond to structure? For example, if you set up a grouping of objects and model what to do with them, is the child's level of play improved upon? (In other words, if you act like the child's frontal lobe does it help the child?) This can be important in sorting out whether a child is having cognitive difficulties or is simply disorganized. Think here about Sara, who was found to be very bright and whose play could be symbolic but was nevertheless described as lacking in elaborate play schemas, especially when she was left on her own, as she often was. Such a child needs structured support from others to organize her play until she can internalize and appropriate the structure for herself.

Problem-solving: What about the child's thinking and problem-solving at a higher level? Can the child use an intended result to guide and plan its actions, or explore how unfamiliar objects function? Formal testing can use, for example, WPPSI-R Mazes to tap into planning skills. But, informally you can see planning skills in any problem-solving task, in the methodical stop-and-think approach, rather than trial-and-error procedures, when a child is asked to put shapes in a formboard or get an object out of reach. In everyday life, you can ask if the child understands punishments and rewards, cause and effect, and can use them to guide his actions. The ability to use past and future to regulate behavior is the foundation for reasoning along causal lines. So ask if the child can so reason according to cause and effect, past and future? For example, was Sara able to automatically tell herself that when Daddy left for work in the morning that he would come back later? Was there a clear temporal organization implicit in her experience that would allow her to use past experiences to give herself the needed reassurance? Was Frank able to automatically remind himself: "When (in the past) I knocked into Bob, the teacher got mad"? Was he able to use this kind of conditional thinking to orient his behavior? Children with organizational and attentional weaknesses cannot automatically regulate their behavior in accord with such "causal" principles.

Cognitive style: What about the child's overall cognitive style? How flexible and naturally methodical is the child? Children with organizational weaknesses, like Sara, are also known to fluctuate in style between an approach that is disorganized, impulsive, or easily sidetracked and one at the opposite extreme of being compulsive, rigid, perseverative. Children with frontal lobe dysfunction can show both these extremes. It seems that the very problems (in frontal lobe dysfunction) that underlie organizational and attentional difficulties may also codetermine defensive style and personality. The child who is highly distractible and unable to plan and guide actions in accord with rules or anticipated consequences can show a propensity to be impulsive in dealing with emotionally-laden issues and to use, for example, avoidance, denial, or blaming others. A child sensitive to experienced disorganization and loss of attentional focus as beyond her control, in an ego-dystonic way, may well opt for over-control and an obsessive style. Children who have difficulty shifting attention and show a perseverative focus may also show a cognitive inflexibility that can appear as an obsessive preoccupation with things. Sara's obsessively anxious quality, seen in her repeated questionings and repetitive behavior at home, may be an offshoot of these brain-based problems as they impact on personality style.

An important clue: Discrepancies among skills

Beyond a more exacting look at the many other areas of possible neuropsychological compromise, which cannot here be discussed, an important clue for detecting the presence of a hidden disability, as well as for understanding its impact on emotional functioning, is the presence of discrepancies in skills.

For example, a child with a language disorder may have poor verbal abilities but excellent non-verbal reasoning abilities. It is important to ask: **How does it feel to a child to experience this discrepancy?** Within the area of language abilities, a child with expressive problems may have adequate receptive skills. Such a child

may experience the frustrating and anger-provoking discrepancy between what he understands and what he feels capable of saying. In contrast, a child like Sara, who has better expressive than receptive skills, constantly faces expectations that are higher than she can verbally meet. People talk and expect her to respond because the impression from her own expressive language is that she has no language problem. Such a child may experience a defeating sense of inadequacy, and withdraw.

If other people in the child's environment don't recognize the discrepancy or know how to account for it, what about the child? What is the child to make of it? The point is that the child can't help but subjectively experience the discrepancy, give meaning to it, and incorporate it into his sense of self. So it is not unusual to find children with fluctuating self-esteem — images of self as good and competent sometimes, and as dreadfully incompetent at other times. How is the child to know, when no one else knows, when to predict that he will be able to do something and when he won't? Esteem issues become critical with such children.

Finding the weaknesses and circumscribing them becomes the goal with such children — in order to "dam the spill" onto personality structure. Simultaneously identifying the child's strengths not only helps the child to compensate for weaknesses and alleviate their impact on everyday life, but also buoys up the child's psychic resilience and consistent sense of knowing what he **can** do.

Possible neuropsychological underpinnings of some common behavioral and emotional problems

When might you start thinking that the aggressive, oppositional, or anxious behavior you're seeing in a very young child masks a neuropsychological difficulty or, at least, is fueled by some underlying neuropsychological problems?

Aggressive behavior: Think of Frank. Was Frank impulsive in his movements because of "intent," or did he have a constellation of problems that clearly went together and supported the inference of impulsivity due to poor frontal lobe function? Did he "want" to knock into children, step on their toys and hands, and charge out of his seat? Or, was his behavior the outcome of difficulties with motor planning and sequencing? Think, too, about how Frank experienced that lack of control over his movements — as a "sensed loss of control," perhaps? — and how a child would react to and give meaning to such an experience — especially when others around him, at home and at school, were interpreting it as intentional "bad boy" behavior. Frank could easily have turned passive into active, and, instead of passively experiencing himself as the victim of his body, he could have counterphobically begun to actively plan aggressive motor acts, so that his feared loss of control could be felt as mastered.

Oppositional behavior: Think about Frank and Sara. With Frank, we saw a lack of response to his teacher's requests and his general stubborn contrariness and refusal to join in on group activities. Was this, perhaps, at least incipiently and at root, part of his attentional difficulties, part of his being "stuck" in an on-going activity, with difficulty shifting to a new one? Was this, at least in part, an underpinning for what appeared to be oppositionalism? With Sara, how much of her inability to tune in to a command had to do with difficulties in keeping track of input from various modalities simultaneously, or to her receptive language problems? It is not unusual for children with receptive language problems to "tune out," especially in classrooms where there are heavy auditory verbal demands — which is most of the time the case. This is why such children can be misidentified as "oppositional" (which, without appropriate support, they can then also become).

Withdrawn/anxious/bizarre behavior: Was anxiety responsible for Sara's withdrawn behavior on the playground and in the classroom during singing time? Or was her behavior in part due to her dyspraxias? Was she withdrawn and non-interactive with others, at least in part, because of her receptive language problems — because of her sensed inadequacy in being able to reliably understand the meaning of what was being said to her? Was her isolation from others fueled also by her organizational difficulties, which so clearly infected her play and her responsivity to others? Sara would go off on tangents and easily "lose set" or focus, as well as the established connection to another. This made her pragmatics look poor, and her interactions lack in extended, reciprocal turn-taking volleys.

Many of Sara's emotional preoccupations and "anxious worries" seemed to be engendered, if not exacerbated, by a cognitive inability to readily shift focus or mood. This "being stuck," overwhelmed by negative affect and tension, and tendency to diffuse anxiety states also had a long history in her sensory integration problems and poor affect processing, as these were overlooked or misinterpreted by others.

Importantly, some of Sara's "bizarre" behaviors seemed very much a part of the particular neuropsychological profile that she showed — that of a semantic pragmatic developmental language disorder. Children with this disorder have much better expressive than receptive skills, excellent rote verbal memory with, however, weak semantic processing or understanding of its content, and organizational problems. Such children, as was the case with Sara, may develop "scripts" that they often rehearse over and over again and either insert at inappropriate times into conversations (because they do not fully understand the content of what they are saying) or use in seeming monologues

Matthew Melmed:

A New Executive Director for ZERO TO THREE

On February 13, 1995, Matthew Melmed joined ZERO TO THREE/National Center for Clinical Infant Programs as its Executive Director, following a nation-wide search.

Jeree H. Pawl, President of the Board of ZERO TO THREE, announced the Board's selection:

Matthew Melmed brings to ZERO TO THREE *an in-depth understanding of social issues and a strong reputation as a strategist, non-profit entrepreneur, and effective manager.* ZERO TO THREE*'s Board and staff have strong clinical and research expertise covering a wide range of disciplines in the infant/toddler/family field. They have, as well, a passionate interest in and devotion to the well-being of all small children and their families. We felt that we needed a person with that same passion, but with the kind of vision and administrative skills needed to shape what we have created over the past 17 years, expand that base, and lead our organization in the most useful and meaningful directions.*

An attorney and Phi Beta Kappa graduate of Harpur College, State University of New York at Binghamton, and the Faculty of Law and Jurisprudence, State University of New York at Buffalo, Mr. Melmed has dedicated his professional life to improving conditions for those who are most in need and least cared for. After working for Connecticut Legal Services, in 1982 he became Executive Director of the Connecticut Association for Human Services (CAHS), an organization which grew under his leadership into one of the largest and most effective state-based, non-profit education, research, and policy centers of its kind. In remarking about the quality and quantity of reports on the state of children provided by CAHS during Melmed's tenure, State Representative John W. Thompson, past chair of the Select Committee on Children of the Connecticut Grand Assembly, stated: "We can't be just sentimental about these things. You really need the facts and figures to make an argument," and the Association under Melmed was "always extremely thorough and well-prepared." The Republican Connecticut Senate Majority leader, a frequent opponent of Mr. Melmed's during the 1980's, observed on the occasion of Melmed's departure from Connecticut that he "always had a compelling argument for why he felt the way he did...He always had reasons for what he believed in, and you could sit down and talk to him about it."

Mr. Melmed has played a key role in a variety of efforts to improve early childhood education, maternal and child health, and nutrition, as well as in understanding and dealing with the many issues and problems embedded in poverty. The Hartford Courant reported that: "Melmed's style has made it easy for him to walk in the many circles necessary to win legislative battles — corporate board rooms, governors' offices, and the homes of people on government assistance." Notes William B. Ellis, Chairman of Northeast Utilities and the head of a committee of corporate executives that has worked with Melmed: "Matthew's whole attitude is one that the more conservative business community can feel extremely comfortable with."

Mr. Melmed has held several appointments to legislative and executive branch task forces and been the recipient of numerous advocacy and community leadership honors, including the Child Advocacy Award from the Collaboration for Connecticut's Children, and recognition by the Lewis Hine Awards for Exceptional Service to Children and Youth from the National Child Labor Committee.

Mr. Melmed expressed his vision for ZERO TO THREE by saying: "I am delighted to join an organization that is working so thoughtfully and with such commitment to ensure that all young children have the opportunities to fulfill their unique human potential. I will consider my time as Executive Director to have been successful if, when my own small children are grown and have children of their own, the incredible and exciting knowledge which now resides in this organization has become **common** knowledge."

with themselves. This, above all, gives others the sense that these children are "bizarre." But if, instead of interpreting this behavior as evidence of social problems and unrelatedness, one listens closely to such rehearsed scripts, one often hears messages from mother and other remembered significant interactions. In other words, sometimes the scripts are not evidence of social **unconnectedness** but, on the contrary, are used by the child as transitional phenomena, to mediate connectedness to others.

So, when you see emotional and behavioral problems, be aware that they may have neuropsychological underpinnings. At the same time, however, because these difficulties are taken up and subjectively experienced by the child and played out for others (where they can be interpreted and misinterpreted) there may well be family problems, esteem issues, and other stresses feeding into, maintaining, or exacerbating the child's difficulties. (Be aware that it can work the other way around, too. Some neuropsychological-looking symptoms may have emotional underpinnings; impulsive, disorganized behavior can also be produced by anxieties and reactions to stress.)

Conclusion

In sum, neuropsychological conditions are taken up actively and psychodynamically by children. They play their part in how self-image, personality, psychological defenses, and relations to others develop. Comprehensive, integrated assessments or neuropsychological assessments that pay heed to psychological dynamics and family systems considerations are a vital tool for differential diagnosis and for providing guidelines for appropriate intervention. The medium for intervention becomes, in part, exploring with the parent who the child is and what the fantasies and possible misreadings are that the parent, because of his or her own history, may have brought to the exchange. Intervention with the child and the parent is guided directly by knowledge of the child's constitutional make-up. Accurate assessment of the hidden disability and of the child's strengths as well as weaknesses can be used to support more effective coping strategies as well as compensatory strategies, and so enhance overall development. Disclosing positive avenues of access to the child — the child's open channels or strengths — while, at the same time, keeping in mind the dysfunctional channels and their impact on both the child and others, can be an important instrument of intervention in the service of adaptive relatedness.

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Notes

1. Notable is the work by the Diagnostic Classification Task Force, co-chaired by Greenspan and Wieder, on "Regulatory Disorders," a new diagnostic category not offered in DSM III-R or DSM-IV, which includes a range of children all of whom have some form of developmental disability along with emotional issues. The cases that will be discussed in what follows could, in fact, be considered examples of "Regulatory Disorders."

2. The heterogeneity of developmental language disorders and the fact that distinct subtypes can be detected through neuropsychological profiles was shown by Wilson & Risucci (1986). Rapin & Allen (1983, 1992) have also described clinical subtypes of language disorders found among DLD children as well as autistic children. The "semantic pragmatic" subtype that Sara showed was first described by Rapin and Allen (1983). In my research, an overlap was found between this "semantic pragmatic" subtype and the neuropsychological subtype "C."

Publications

Putting Families First: America's Family Support Movement and the Challenge of Change (1994) - Sharon L. Kagan and Bernice Weissbourd, editors (Jossey-Bass Publishers, 350 Sansome Street, San Francisco, CA 94014) $45.00.

This volume, developed with support from the A.L. Mailman Family Foundation, chronicles, explores, and analyzes the changes that are occurring in both the context and content of the family resource movement and seeks to "challenge the thinking of the field regarding second-decade strategies" for the movement. The volume looks at the changing context for family support; strategies for infusing family-supportive principles into school systems, social services, the workplace, religious communities, and the criminal justice system; programmatic changes and challenges (including the critical issue of how to provide adequate growth-fostering support and direction to family support workers) within the family resource movement; and policy changes at the community, state, and federal level.

Contributors to the volume include, among others, Ann Adalist-Estrin, Andrew Billingsley, Barbara T. Bowman, T. Berry Brazelton, Urie Bronfenbrenner, Charles Bruner, Judy Langford Carter, Frank Farrow, Ellen Galinsky, James Garbarino, Ruth W. Massinga, Judith S. Musick, Peter R. Neville, Dolores G. Norton, Douglas R. Powell, Frances Stott, and Barry Zuckerman.

Treating Troubled Children and Their Families (1994) - Ellen F. Wachtel (The Guilford Press, 72 Spring Street, New York, NY 10012) $30.00.

This book argues that the reason family therapy has not fully taken hold in the treatment of problems centered on children's difficulties is that in their efforts to develop strictly systemic perspectives, family therapists have tended to ignore what has been learned about therapy with children. Wachtel argues for a three-pronged child-in-family approach in which: 1) the symptomatic behavior is blocked; 2) the unconscious concerns that made the symptom necessary are addressed; and 3) the systemic issues surrounding the child's difficulties are explored and worked with. She describes strategies for meeting with parents alone, family meetings, individual sessions with children, and specific interventions based on psychodynamic formulations. These approaches are illustrated in five case studies.

The State of America's Children, Children's Defense Fund 1994 Yearbook (1994) - Children's Defense Fund (CDF, 25 E Street, NW, Washington, D.C. 20001) $14.95.

This yearbook provides data in the areas of family income, health, child care and early development, children and families in crisis, housing and homelessness, hunger and nutrition, adolescent pregnancy prevention, and youth development. In "one day in the life of American children," for example, 3 children die from child abuse, 2,781 teenagers become pregnant, 1,200,000 latchkey children come home to houses in which there is a gun, and 307 children are arrested for crimes of violence.

The yearbook describes government-sponsored programs that are in place and suggests ways in which some of these programs can be augmented by public participation as well as corporate funding. Special emphasis is given to the epidemic of violence in America.

More Than Kissing Babies? Current Child and Family Policy in the United States (1994) - Francine H. Jacobs and Margery W. Davies (Auburn House, 88 Post Road West, Westport, CT 06881) $19.95.

This volume uses a case study approach to child and family policy, as implemented by government at the local, state, and federal level. Authors draw on the fields of developmental psychology, political science, social history, early childhood education, and public policy to analyze policies that are meant to promote the well-being of children and families in the United States. Reviewing major policy initiatives in the 1980s and 1990s, the volume explores the political economic history of the care of children, studies various ways in which dependent children and their families have been and are being served, chronicles the emergence of family support programs, reviews the implications of the Baby Doe laws, and examines the Massachusetts Day Care Partnership Project.

Fatherless America: Confronting Our Most Urgent Social Problem (1995) - David Blankenhorn (Harper Collins Publishers, 10 East 53rd Street, New York, NY 10022-5299) $22.00.

More than half of America's children will spend at least a significant portion of their childhoods living apart from their fathers. David Blankenhorn argues that fatherlessness is the leading cause of declining child well-being in our society and the cause of its most urgent problems, including domestic violence, crime, adolescent pregnancy, child sexual abuse, and violence against women. Written for the general reader, with references to the professional and research literature, the book provides an historical look at fatherhood; examines the types of fathers currently seen in American society and offers strategies to get American society back on the road away from fatherlessness and on to fatherhood.

An Ecological Approach to the Study of Child Care: Family Day Care in Israel (1994) - Miriam K. Rosenthal (Lawrence Erlbaum Associates, Inc., Publishers, 365 Broadway, Hillsdale, NJ 07642-1487) $36.00.

In order to uncover basic environmental processes responsible for developmental outcomes among children in child care, the author suggests, a research strategy should consist of a careful articulation of the relationship between the developmental goals set for child

Remembering Shirley Zeitlin

Shirley Zeitlin, Ed.D., a psychologist and friend of ZERO TO THREE, died of cancer on January 27, 1995. Shirley had an indomitable spirit that was prized by her colleagues — she preferred the excitement of the roller coaster to the routine of the merry-go-round. Consequently, she chose a professional career of challenge, and a personal life of adventure in world travel.

Shirley first directed the child study center at the State University of New York at New Paltz before relocating to northern New Jersey to develop a graduate program in early childhood special education at Montclair State College. In the early 1980s, she joined Gordon Williamson at the Kennedy Medical Center in Edison, New Jersey. They formed a partnership that explored ways to support the coping resources of young children with special needs and their families. They wrote journal articles related to human adaptation, developed an instrument to assess the coping styles of infants (the Early Coping Inventory), and in 1994 published the book Coping in Young Children: Early Intervention Practices to Enhance Adaptive Behavior and Resilience.

Shirley Zeitlin made many contributions to the emerging specialty of early intervention through active involvement in national organizations. As chair of the Government Relations Committee of the Division of Early Childhood/Council for Exceptional Children, she was instrumental in the passage of P.L. 99-457. This legislation encouraged states to develop a comprehensive service delivery system for infants with developmental disabilities. From 1988-1990 she served on ZERO TO THREE's TASK (Training Approaches to Skills and Knowledge) Advisory Board, which developed guidelines for promoting the competence of infant/family practitioners and programs.

Shirley Zeitlin was a strong believer in having a vision for the future. She encouraged us to look at life as a challenge and to take at least one ride on that roller coaster.

— G. Gordon Williamson

ZERO TO THREE / National Center for Clinical Infant Programs is grateful to the family of Shirley Zeitlin Gardy, who requested that contributions in her memory be donated to ZERO TO THREE.

Letter to the Editor

I read Suzi Tortora's article, "Join my dance: The unique movement style of each infant and toddler can invite communication, expression and intervention" (Zero to Three, August/September, 1994) with excitement and delight. Her words, and those of Steve Harvey and Susan Loman in the same issue, speak eloquently to the power of dance/movement therapy as a clinical approach to early intervention.

Working as a dance therapist with preschoolers who present with language delays, I learned that although these children do not speak, they express themselves through a complex kinesthetic language. Laban Movement Analysis (LMA) offers a systematic way to observe how a child's rhythms, approach to space, recurrent movement themes, and qualitative changes in exertion combine to communicate a personal story. Dance therapy equips the practitioner with skills to wait, to develop kinesthetic empathy, and to witness the movement and stillness that emerge in the child.

When I became an infant development specialist working with babies and their parents in dyads, I found my dance therapy background to be invaluable. Not only does it enable me to perceive intricacies in an infant's movement repertoire and respond to these cues, it also provides me with an easily understood vocabulary to use in discussing my perceptions with parents. Through this process, what a parent perceives preverbally can be identified, honored, and spoken. Once I perceive an infant on a kinesthetic level, I can recognize a parent's experience of synchrony or disconnection.

Training in dance/movement therapy and Laban movement analysis taught me how to use movement as a boundary and a support for relationships. For infants and young children, the body reveals one's experiences and emerging sense of self. Tortora's article emphasizes how aspects of dance therapy and LMA can enrich and expand clinical work with infants and their families. Thank you for publishing testimony to what these fields have to offer early intervention.

Catherine Thomas MA, MS, ADTR, CMA
San Jose, California

care (which may vary among cultures and societies), the environmental processes relevant to attaining these goals at home and in child care, and the interaction between these processes and the individual characteristics of children. She uses such a strategy to examine the experiences of infants and toddlers in Israel's sponsored family day care system.

Rosenthal observes that the data of her study argue against a global definition of "quality of care." The author argues that future research on children in child care needs to define quality of care in reference to the cultural values and the developmental goals the society sets for its child care, as distinct from home care. Special attention should be given to such issues as the early development of peer relations and the impact of how dual socialization (at home and in the child care context) affects children's future development as well as their current life and well-being.

Videotapes

Introduction to the ECO Program. Produced by James D. MacDonald, The Nisonger Center, Ohio State University, Columbus, OH and distributed by Child Development Media, Inc., 5632 Van Nuys Blvd., Suite 286, Van Nuys, CA 91401, tel: 800/405-8942. 45 minutes. Manual included. $70.00.

ECO is an approach to assessment and training that shows adults how to help preconversational children learn to communicate through balanced interactions with adults. The tape provides an introduction to the principles, goals, and strategies that parents and professionals can use to help children with delayed communicative development become more socially engaging, more interactive in their relationships, and more active learners in all of their encounters with others. The ECO program stresses adult-child interaction as the basis for a child learning social play, turn-taking, preverbal communication, language, and conversation. It also increases social interaction and language learning for children with a variety of special needs, including developmental disabilities, motor delays, behavioral disorders, and autistic-like characteristics. The approach has been clinically tested with infants at risk and with older children with a variety of communication delays.

Spanking: What To Do Instead. Produced and distributed by Family Development Resources, Inc., 3160 Pinebrook Road, Park City, UT 84060, tel: 800/688-5822. 30 min. With handbook. $75.

This video presents positive nurturing parenting techniques to promote healthy, desirable behaviors in children and is designed to help viewers recognize that any degree of violence toward children is inappropriate. The video and accompanying handbook are intended for use interactively with groups of parents, who have an opportunity to view typical parent-child problems and to offer their suggestions and alternatives to corporal punishment. Professional adult and child actors present difficult and challenging family situations that often lead to shaking, hitting, and spanking children. At the moment of confrontation and the use of corporal punishment, the tape is stopped. Viewers are asked to consider what occurred and to brainstorm other solutions. The tape is resumed, and nurturing parenting techniques are presented.

Conference Call

May, 1995

May 6: Eliot-Pearson Department of Child Study, Tufts University, and the Boston Institute for the Development of Infants and Parents (BIDIP) will sponsor a meeting in Medford, Massachusetts on "Vital Families: Studying and Serving America's Children in the Post-Modern Era." Keynote speakers will be David Elkind and Sylvia Ann Hewlett. For information, call (617) 628-5000, x3355.

June, 1995

June 21-23: The Infant and Parent Development Program, Bank Street College Graduate School of Education, will hold the eighth annual Infancy Institute, in New York City. Speakers will include Edward Tronick, Ellen Galinsky, Stella Chess, and Margot Hammond. A two-day course on dynamic movement development will be held June 19-20. Contact Dr. Nancy Balaban, Bank Street College of Education, 610 West 112th Street, New York, NY 10025, tel: (212) 875-4713, fax: (212) 875-4753.

June 25-27: Parents as Teachers National Center, Inc. will sponsor a national conference in St. Louis, Missouri with the theme, "Joining Forces for Young Families." Speakers will include T. Berry Brazelton, H. Stephen Glenn, Ann Pleshette Murphy, and Leonard Olguin. Contact Parents as Teachers National Center, Inc., 9374 Olive Boulevard, St. Louis, Missouri 63132, tel: (314) 432-4330, fax: (314) 432-8963.

June 26-30: The Department of Child and Family Studies, College for Human Development, Syracuse University, will sponsor the 19th Annual Quality Infant/Toddler Caregiving (QIC) Workshop, to be presented by Dr. Alice Honig in Syracuse, New York. Contact Holly E. Brophy, QIC, 201 Slocum Hall, Syracuse University, Syracuse, NY 13244-1250, tel: (315) 443-2757.

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is published 6 times per year. Subscriptions cost $37 per year, $69 for 2 years and $99 for 3 years. Subscribers may order additional copies of **Zero to Three** for distribution to staff or students at a rate of $20/auxiliary subscription/year. **Zero to Three**'s federal ID# is 52-1105189. Telephone orders may be placed by calling 1-800-899-4301.

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